'IN THE PIPELINE': A QUALITATIVE STUDY OF GENERAL NURSE TRAINING

~~WITH SPECIAL REFERENCE TO NURSES' ROLE IN HEALTH EDUCATION~~

BY

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(1987)

Dissertation submitted in part fulfilment of the requirements
for the degree of Ph.D. University of London, Institute of Education

ABSTRACT

This thesis reports on the exploration of a problem in nurse training, the failure of nurses to fulfil a health education role. This problem is explored using a qualitative methodology which incorporates unstructured interviewing and participant observation. The study population comprised both student nurses and significant others in the hospital setting. The study is particularly concerned with the experiences of the student nurse as she progresses through training. Because she is both learner and worker, her experiences both in the wards and the school of nursing are considered. These experiences are explored within the framework of occupational socialization studies, with the assumption that both 'objective' and 'subjective' reality must be explored if the socialization process is to be understood. Although a framework for reporting is imposed in constructing this account of training, a theoretical model is not imposed in the process of data collection or data assembly. Data are presented in such a way that student nurses are allowed to 'tell their story'.

This study identifies a hidden curriculum in the hospital training schools studied. Accounts suggest that student nurses experience powerlessness, uncertainty and depersonalization; this experience is conceptualized as 'pipeline status'. It is suggested that this results in a compliance and a conformity on the part of individuals as they depend on existing structures and routines to 'get-by'. This 'pipeline status' has repercussions for health education and indeed for any development of the nursing role as it prepares the nurse for a very specific work role in a particular type of organization. The report concludes with a discussion of the implications of 'pipleine status' for a nursing role in health education and for the future training of nurses.

ACKNOWLEDGEMENTS

I wish to express my thanks to everyone who helped me in carrying out this study. To my supervisor, Mr. Alan Beattie, Department of Health and Welfare Education, University of London Institute of Education I am indebted for his advice and encouragement at all stages of this project.

I am grateful to the Health Education Bureau, Dublin for the financial assistance to undertake this study. A special word of appreciation is extended to their Research Officer Aidan O'Connor and to the library staff, particularly Aine Ni Aodgain who was most helpful in the early days of this study.

Grateful thanks are also extended to Rev. Professor Conor K. Ward, Department of Social Science, University College, Dublin for his interest and assistance in the course of my fellowship.

To Dr. Robert Dingwall and to Dr. Kathleen Lynch, for reading draft material, a special thanks is extended, their interest and comments were greatly appreciated.

Thanks are also extended to the Nursing Board and most especially to Maria Neary, Assistant Education Officer, for her assistance in providing information.

To all who facilitated this study, those who granted access to the hospitals and most especially to respondents who participated directly in the study, my debt is enormous and their generosity much appreciated.

To all who assisted in the producion of this study, most especially in the final steps with proofreading and other tasks, particularly Anne Cleary, Pauline Faughnan, John Heuston, Betty Hilliard, Deirdre Kirke, Dr. Kathleen Lynch and Monica McElwee, I am especially grateful.

The thesis was typed by Nuala Breslin. I am more than grateful and most appreciative of her patience and efficiency. I am indebted to Anne Coogan who was most generous with her advice and who assisted with the final production of the thesis.

My sincere thanks to my family and friends who in numerous ways contributed to the completion of this report. Special thanks to Richard Treacy who was always on hand to provide assistance. A very special thanks is extended to my mother, Mary Treacy, for her encouragement and help and to John Heuston for his moral support and invaluable help at all stages of the project.

CONTENTS

CHAPTER 1

NURSES AS RELUCTANT HEALTH EDUCATORS: A PROBLEM OF PROFESSIONAL TRAINING?

INTRODUCTION

The central concern of this thesis is a health education role on the part of nurses. The study arose out of what has been described as a problem (Syred, 1981) and as a challenge (Smith, 1979), that is, the failure of nurses to fulfil a health education role. The focus for the study developed from my work on the nurse as a 'deferential worker' (Treacy 1979, see ch. 2) and an awareness of gaps in the nursing role in relation to health education. This introductory chapter looks briefly at the problematic nature of the nurse's role in health education and considers a direction for the study of the problem.

APPROACHES TO HEALTH EDUCATION

A number of models of health education have been developed: These include medical, educational, media, community development, and political models (Coutts and Hardy, 1985; Ewles and Simnett, 1985). They can be summarized as follows. The medical model rests on the assumption that expert advice will persuade and the practitioners' role is that of expert informant. The educational model assumes that potential for self-reliant health-promoting behaviour can be developed in individuals through education; in this model, the practitioner adopts the role of enabler or educator. The media, community development and political models respectively assume; that individuals can be manipulated to follow a

healthy life style; that they have ability and they will want to use it to improve their health chances as they see them; and that changes in the institutions of society are necessary if health is to be improved. In these three models the practitioner variously adopts the role of 'persuader', 'enabler', and 'provocateur' (Coutts and Hardy, p.24). As can be seen, the assumptions and the role of practitioner vary in each model.

A basic premise in health education is that progress can only be made through the informed co-operation of individuals. It demands active participation of individuals in making their own health choices. Baelz (1979, p.32) writes:

> "...in the context of human values health education is never simply the imparting of information by the one who knows to the one who does not know. It is a communication of insights, a shared exploration of shared humanity, a venture of persons in the making."

The World Health Organization (1974) states that health education should be:

> "Based on the assumption that the responsibility for health maintenance and the prevention and cure of illness is the prerogative of the individual who has the right to decide about his health related and health directed behaviour." (World Health Organization, 1974, p.3).

Despite sharing these premises, very sharp distinctions characterize the five models. In particular, the educational and medical models tend to polarize on the basis of the assumptions which underline them.

The medical model is characterized by a directiveness which is made manifest in the paternalistic or prescriptive approach of many health professionals. Whereas I suggest that both educational and community development approaches, on the other hand, have in common an 'empowerment' aim, as the health educator is seen in the role of enabler as opposed to 'expert informant', 'persuader' or 'provocateur' (Coutts and Hardy, 1985, pp. 21-22).

The 'empowering' educational model of health education indicates an

approach which is in total contrast to the paternalistic approach to clients adopted by many health professionals. It suggests the need for health professionals to step outside traditional roles. Freidson (1975) notes that conflicts may arise if patients try to control encounters with physicians. Within traditional health care roles the carer does not usually assume the role of educator, as envisaged by the World Health Organization (1974), but more that of the indoctrinator who is not to be questioned. The extent to which the approach to health education among medical professionals ignores the dimension of empowerment, and in fact has a 'disabling' function in regard to the patient, is illustrated by Atkinson (1979). He notes a failure of health professionals to respond to patients' needs and, I suggest, identifies a lost opportunity for health education. He indicates how traditional patient roles are perpetuated, stating:

> "Many patients in the teaching hospital are in the position of being 'well-informed'. But their own information and understanding is not routinely used as a resource in the conduct of bedside teaching; indeed its appearance can prove quite disrupting to the entire exercise. The particular version of medicine which is reproduced on such occasions thus recapitulates the passive and subordinate position of the patient as a prerequisite to the display of expertise on the part of the students and their teachers." (Ibid. p. 99).

Patients do not normally enter into discussion of their illness or of the health care they receive with those who provide the service and consequently they have little opportunity to learn from their carers. Within the health services, a medical model of health education is likely to be the norm. As indicated, this model is in contrast to the educational model informed as it is by the ethos of empowerment.

A NURSING ROLE IN HEALTH EDUCATION

Nurses in the main operate within the health services and a medical model of care. There are three stages in the preventive process at which a health education role by health care professionals is appropriate; namely,

(what has been identified as) the primary, secondary and tertiary stages (1). Primary prevention aims to prevent disease occuring, secondary prevention aims to arrest disease with total return to complete health, whilst tertiary prevention tries to reduce the disability caused by disease if a complete return to health is not envisaged. At a general level, primary prevention may occur by general measures directed at that stage in an illness when pathology can be reversed; for example, early detection of disease through screening comes into this category. Secondary prevention aims to detect and halt advancement of the disease. Tertiary prevention occurs when the disease is advanced or incurable. It aims to prevent deterioration, relapse and dependency. As Tones and Davison (1979, p. 30) point out such "preventive care would be largely of a rehabilitative and even pallitive nature". At a local level, the individual nurses' health education role may vary, but, within the above levels, the stages at which different nursing specialities may intervene to provide health education can be readily identified. For nurses generally, a health education role may exist at any one or more of the above levels. Thus, the hospital based nurse may find her health education role confined to secondary and/or tertiary prevention. Given these possible stages for nursing intervention, I will now explore how they relate to conceptions of nursing practice.

Questions on the role of the nurse as health educator are, of course, closely bound up with the question so often addressed in nursing literature, namely, 'what is nursing?'. One of the most widely accepted role definitions of nursing is Henderson's (1977), whose definition is as follows:

> "The unique function of the nurse to assist the individual sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible." (Henderson, 1977, p. 4).

It can be seen that this definition is so all encompassing that it covers

all helping activities, be they teaching or caring for physical needs. This section attempts to consider something of what that definition means in practice for nurses as it explores their nursing role; a role which it is suggested encompasses health teaching (Redman, 1976, ch. 1; Smith, 1979). Redman (1976, p. 10) documents the case for patient teaching by nurses. She states:

> "Perhaps it is most useful to nurse practitioners to view all interaction with patients as contributing to the broad process of objectives of teaching-learning. For example, each time nurses are with patients, they are assessing patient needs, some of which can be met by providing patients with information, clarifying their thinking, reflecting their feelings, or teaching them a skill. Nurses also communicate non verbally and by example about such topics as health and good hygiene practices."

Henderson's definition implies a health education function for the nurse as it implies an enabling role for the nurse in facilitating patient independence (Treacy 1982). Literature in the area suggests that the health education model most appropriate to the nursing role is the educational model, informed as it is by the emphasis on empowerment.

Current models of nursing (Orem, 1971; King, 1971; Rogers, 1970; Roy, 1974), with their capacity for identifying needs at a variety of levels and their stress on the facilitation of patient independence, provide far greater scope than ever before for an educational model of health education in nursing practice. Wainwright (1982) indicates the way in which the Nursing Process can assist the nurse in meeting health education needs in patients. Armstrong-Esther et al. (1985) indicate the value of a partnership-in-care between nurse and patient. While recognising that all five models may help nurses to meet the variety of health needs they encounter (Randell, 1982), Coutts and Hardy (p.39) state that in nursing:

> "The model of health education proposed is an educational one. The underlying assumption is that the nurse has special skills which she will exercise in assessing people's teaching needs, in planning and conducting appropriate teaching and in evaluating the outcome of her teaching plan."

They cite the Scottish National Nursing and Midwifery Consultative

Committee (1983) which suggests that the Nursing Process should include health education as it helps individuals to recognise and take enlightened decisions about their health capabilities and health behaviour. These generally accepted views of nursing can be seen to be consistent with the empowering, educational model of health education. In Ireland, the Working Party Report (1980) supports Henderson's definition of the nursing role (2), which it is suggested is captured (along with all other definitions) in the one they adopted: The definition is based on a study carried out by the International Council of Nurses. It concludes as follows:

> "The nurse is responsible for planning, providing and evaluating nursing care in all settings, for the promotion of health, or support in death, prevention of illness, care of the sick, rehabilitation and functions as a member of the health team." (Working Party Report 1980, 3.2, p.29).

This definition quite clearly recognises a health education role for nurses. However, it must be noted that it is based on nursing theory developed at an international level by nursing elites. Whilst health education and nursing practice are complementary and apparently mutually inclusive at a theoretical level, nurses in Ireland, have in the main operated within a disease focused, task-orientated system of care provision, and nursing theory fails to make an impact on practice (Working Party Report, 1980). This failure is reflected in an extensive nursing literature on theory-practice gaps. In Canada, where university education is the norm and nursing theory more developed, Rosenthal et al. (1980, p. 131) note four major problems with which nurses have difficulty. One is particularly relevant to a nursing role in health education, viz the problem of achieving the active participation by patients and their families in medical care. It suggests that few nurses are oriented towards facilitating self-care. Rosenthal et al. (1980) note that changes in this direction are likely to be perceived as threatening by health personnel. In concluding, they suggest:

"...it is the uncertainty and loss of control associated with active participation which appears to be most threatening to health professionals, including nurses." (Ibid. p.138).

Research has shown that nurses have great difficulty in communicating and interacting with patients who wish to take any degree of responsibility for their own health; it would appear that patients who indulge in excessive information-seeking from nurses and medical staff, and those who fail to conform to the ideal 'dependent' patient are likely to be viewed as difficult, awkward, unpopular patients (Stockwell, 1972; McIntosh, 1977; Rosenthal, et al. 1980). Within nursing, confusion may exist with regard to the nursing role in health education. Perkins (1980), in a report of a developmental workshop on health education and nursing practice, indicated that it is necessary to define more clearly what is health education in nursing practice. The report suggests that what is required is evidence of what actually takes place in nursing settings. The Health Education Council's (1980) follow-up survey of schools of nursing gave further insight into the gaps which existed with regard to the preparation of student nurses for a health education role. It found little agreement on what constituted health education, and less than half the schools which responded had a working definition of health education (3). In Ireland, there has never been a systematic attempt to get the co-operation of health professionals in health education, other than those already working in the community. To date, it would appear that there has simply been an emphasis on, and a recognition of, health education operating only at the primary level - e.g. a health education role is recognised for the community nurse (4).

NURSES' FAILURE AS HEALTH EDUCATORS

In Britain it is suggested (Smith, 1979; Syred, 1981) that nurses have failed to realise their potential as health educators. Melia (1981) reports how 'talking isn't nursing work', Fretwell (1982) notes how routine working prevented nurses responding to patients as individuals, a focus which is central to the definitions of nursing and health education proferred earlier. Faulkner and Ward (1983) indicate that nurses do not have the knowledge needed to function as health educators.

Essential components of health education are communication and teaching, both of which seem to fare badly in the health service. One way of considering how effectively the hospital nurse acts as a health educator, is to consider how effectively she communicates with patients. Casee (1975) notes how the hospital fails to function as a therapeutic community mainly because of poor communication. A number of studies indicate the problematic nature of communication in hospital (McGhee, 1961; Cartwright ,1964; Ley and Spellman, 1967; Skeet, 1969; Stacey, 1970; McIntosh, 1977; Ashworth, 1980; Johnson, 1986). Syred points out that nurses do not readily undertake the role of educating patients in their care and that communication with patients is very limited, nurses approaching patients only when they have a specific task to perform. Also, patients are reluctant to question or to make demands on the nurse's time, even for simple necessary requests, like bed-pans. McIntosh (1977) in his study of communication in a cancer ward, indicates that discussion of patients' illnesses by nurses was relatively infrequent and also less likely to occur in the presence of a third party. He noted the almost continuous interaction of patients and nurses, with several encounters often occurring simultaneously. McIntosh also showed how doctors routinised their communications with patients, as it provided a means of

managing uncertainty, consistent with the doctors' beliefs about patients' desire for information and obviated the necessity of making individual decisions. Skeet (1969) indicated that fifty nine per cent of patients sampled received no advice on discharge from hospital other than of a very general nature; forty five per cent claimed that they needed advice and reassurance about the effects of drugs and treatment and of how much activity they should undertake. In the only Irish study of the hospital consumer to date, Johnson (1986) found that the most often reported area of dissatisfaction with regard to obstetric patients was the lack of information. This suggests that an important prerequisite to a nursing role in health education is missing, viz effective communication. Stacey (1970, p. 157)in a study of communications in hospitals notes that the research:

> "found communication between the hospital staff and the childrens' parents was felt to be unsatisfactory... It is also clear, that although the extent to which parents are prepared to accept the hospital authority varies, statements made by hospital personnel, even the most junior, are perceived as authoritative. Doing what the hospital says is quite an ingrained habit. Alongside this is a reluctance felt by many to challenge this authority in any way."

This illustrates the potentially significant position of hospital staff as health educators. A number of writers (Hayward, 1975; Boore, 1979; Revans, 1962; Egbert et al., 1978; and Moss and Meyer, 1966) have observed the therapeutic effect of information in their respective studies. Research suggests that effective communication including anticipatory guidance is the basis of quality patient care, judged from the patient's point of view and effectiveness of care.

The rhetoric of nursing theory, while being compatible with the philosophy of health education,is often seen to stand in stark contrast to nursing practice. An extensive literature on the gaps between theory and practice in nursing attests to this. In recent years, a number of studies in the United Kingdom have been concerned with the training of student

nurses (Melia, 1981; Gott, 1984; Birch, 1975; Gallego, 1983; Fretwell, 1978, 1982) all found that gaps between service and education, between theory and practice, presented as problems in varying forms. Gaps between theory and practice are also identified as problematic in Irish nursing.

> "The Working Party is concerned at the evident gap that exists between the theory of nursing as taught in the classroom and relevant clinical experience...The Attitude Survey (of trained staff) show that most nurses wanted improvements in the link between theory and practice - 78% of the staff surveyed considered it necessary to improve this link." (Working Party Report, 1980, 7.4.5, p.109).

I wish to suggest that at a more general level theory-practice gaps reflect the problem of nurses' failure to act as health educators. It is to be presumed that an understanding of nurses' reluctance to fulfil a health education role will also lead to an understanding of the failure of nursing theory to make an impact on care.

Reasons for Failure

Existing work on nurses has not specifically examined reasons for their failure to perform a health education role, although Melia's (1981) study and other studies (Revans, 1964; Menzies, 1970; Faulkner and Ward, 1983) indicate possible reasons for failure. Revans noted poor nurse-patient interaction and poor interaction between medical and nursing staff and associated it with low self-esteem among nurses. Menzies also noted the way nurses feel undervalued as they perform low-level tasks, whilst Bush and Kjervick (1979) note the nurse's lack of assertiveness and poor self-image. Dyer et al. (1975) indicate a relationship between nurses' self-image and quality patient care.

My own work on deference and the training of student nurses (Treacy, 1979), indicated some of the organizational constraints which shaped the nursing role. When reconsidering this earlier work in the light of a nursing role in health education I felt that an investigation of the preparation for the nursing role would assist in understanding the problem.

My study appeared to suggest that nurses' failure as health educators might be linked to the way in which they learned to see and perform their nursing role. Although only an exploratory study (Treacy, 1979), it suggested that nurses learn to be deferential workers in the hospital setting and that a particular role and position are learned by and made available to nurses in hospitals. I suggest that this is likely to affect the way they communicate and interact with patients.

The foregoing suggests that an understanding of how the nurse's self-image and role are created and maintained in the hospital environment is necessary; information is required on the nurse's training and work situation, if some understanding of communication problems and of theory-practice gaps is to be reached. For example, an examination of the syllabus of Training for Registered and General Nurses published by An Bord Altranais (1979) gives only a general idea of the approach to training. Items to be covered in the course of nurse training are simply listed, with little outline or discussion of content, and interpretation of subject matter is left up to individual schools. Health education is a heading under which the words mental and physical health are listed; no further elaboration is given for the benefit of nurse teachers or indeed student nurses. While this suggests a 'content based syllabus' which places an emphasis on uncritical acceptance and transmission of what is presented, and a task-orientated approach, I suggest that simple examination of the training syllabus for health education content and orientation does not give sufficient information on the problem, because it fails to consider the overall socialization of the nurse. Anderson (1979, p.24) points out in relation to preparation for a health education role that "Individual intuition is no basis for planned intervention" and

> "only if the working context of the practitioner is thoroughly investigated and the results of that investigation included in any programme, scheme or advice offered to the practitioner will that programme, scheme or advice have a fighting chance of implementation..." (Ibid. p.23)

Other studies have addressed this area; in the United States, Davis (1975), Olesen and Whittaker (1968), Kramer (1974), and Simpson (1979), have been concerned with the acquisition of professional identity. However, although they have focused on student experiences, apart from Kramer (1974) they have reflected a taken-for-granted acceptance of the professional role as they are concerned with 'ways of becoming'. Kramer notes the 'reality shock' experienced by the newly qualified nurse as she comes face to face with the reality of practice and finds that theory is not relevant.

In United Kingdom nursing research, most work concentrating on nursing's failure to link theory and practice has focused on training on the ward (Fretwell, 1982; Ogier, 1981; Orton, 1981) locating causes for this gap within the ward sisters' management styles. Fretwell (1982) suggests that student nurses' socialization may even divert students away from patients' needs. She states:

> "There is a sense in which the socialization processes through which nurses pass, divert the learners attention away from the patient, so that needs which fall outside the routine are ignored or regarded as a nuisance." (Ibid. p.113)

Fretwell (1978, p. 355) in concluding her study noted that whilst her work had focused only on the conscious learning process of students, 'unconscious' socialization processes were also important, and that this 'hidden curriculum' was a vast area which required further exploration. The 'hidden curriculum' refers to a concept developed in work on education. It focuses attention on hidden aspects of schooling, such as the unanticipated, unplanned effects of education structures. It points to the incidental learning that can take place (Snyder, 1971). To date, few studies of student nurses have focused on a 'hidden curriculum'; in this respect, two studies are of particular relevance (Melia 1981; Clinton 1982). Melia's study, while not directly focused on the theory-practice problem, attempted to understand students' experiences of general nurse

training. Clinton considered the way in which theory-practice gaps were perpetuated as psychiatric student nurses encountered a 'hidden curriculum' in the school of nursing.

I suggest that as an initial step to understanding the trained nurses' failure to function as a health educator, their training experience must first be examined. To ignore the way in which the hospital training school transmits and promotes versions of nursing practice is to fail to understand the training experience and the nursing role. If problems of practice are to be understood, if nurses are to function as health educators both inside and outside hospital services, if the theory and practice of nursing is to be brought closer together, then the 'hidden curriculum' of nurse training must be the subject of investigation. That the area of training nurses is in need of researching is recognised in the Working Party on General Nursing (1980). This report states:

> "Methods of selecting and counselling students, syllabi and curricula of training and traditional methods of imparting nursing knowledge need to be examined critically. Evaluation of programmes of education must also include examination of student nurses' attitudes and career aspirations. The learning environment and involvement of students in their own learning process are other areas which require research." (Ibid. p.80)

SUMMARY

To summarize, the fact that nurses fail to realize a health education role formed the starting point for this study. A consideration of health education and nursing theory indicated a basic compatibility of aims and philosophy. But problems of practice exist, and health education is not a well defined or easily incorporated component of the nursing role despite its apparent congruence with models of nursing care. The question of why nurses have difficulty communicating with patients (5), can be extended at a macro level to encompass nursing theory, to ask why nursing theory and

all that it implies is not incorporated at the level of practice? An examination of the nurses' preparation for her role is considered necessary. It is suggested that a study of students' training experiences is required if one is to understand the subsequent orientations and work role adopted by trained staff, and the importance of a hidden curriculum in this respect is suggested. In what follows, this study explores a hidden curriculum of general nurse training by examining the experiences of the student nurse as she progresses through training. From existing work, there is every indication, that the 'unconscious learning process' needs examination, and that the process of training needs to be understood from the student's point of view. This research project commenced with a very specific aim: To identify the way in which the nurse learns her role as health educator and to identify orientations and work patterns which appear to hamper her in this role. In the course of the literature review, this aim was extended to encompass related problems of practice. This study broadens the area of research to ask the questions:

1. What are the training experiences of student nurses?
2. How is nursing transmitted in the hospital training school?
3. What are the implications of what is transmitted for the nurse's potential role as health educator?

To conclude, this study focuses on the socialization experiences of student nurses, by examining their experiences as they progress through training, the messages transmitted to them, and the orientations acquired by them in the wards and school of nursing. It is proposed that such a study will assist in understanding nurses' failure as health educators and the failure of nursing theory to make an impact on this aspect of care. By way of introduction to the study, the remainder of this chapter discusses the context of nurse training and practice in Ireland.

ASPECTS OF NURSING PRACTICE AND TRAINING WITH REFERENCE TO THE IRISH EXPERIENCE

Irish health service provision resembles the British structure prior to 1948 (Hensey, 1975; Maynard, 1975; The Working Party Report on General Nursing, 1980; Leydon, 1980) with a mix of public and private patients in all hospitals. Those above a certain income level contribute to a voluntary health insurance scheme, and others hold a means tested medical card entitling them to free general practitioner services and hospital care. A major difference between the British and Irish structure is the absence of the National Health Service. Nursing organizational structures resemble those existing in Britain before the Salmon Report (Ministry of Health 1966), with nurses almost absent from the hospital management structures and with a matron as head of the hospital training school (6, 7). In Ireland, hospital centred training is the accepted norm, be it in a Local Authority Hospital or a Voluntary Hospital (8). With this hospital centred training scheme, problems arise regarding the interrelationship of theory and practice (Working Party Report, 1980). The practical experience which the student needs to complete her training is based on satisfying the service needs of the hospital. Theory-practice problems also exist elsewhere. Alexander (1982, p. 64) noted in her Scottish study that:

> "The most powerful force, in terms of student nurse learning of behaviour and values was undoubtedly the hospital - the ward environment and the ward sister. The weaker influence, feared by some to be becoming almost irrelevant to patient care (Altschul, 1978) was the school, and the nurse teachers."

This service location has also weighed nurses' training and work experience in the direction of medical needs and values. As Fretwell (1978, p. 11) notes, the medical profession have benefitted considerably from the apprenticeship system:

"For many nurses, the apprenticeship system of training has meant

> learning to do and doing whatever a doctor in a particular ward wanted doing, in this particular way."

In the United States, Ashley (1976) discusses how such a system of training exploits the work of nurses, and she suggests that it has been responsible for making the scope of nursing work narrow and rigid. In Ireland, student nurses are not simply students but are very much service employees of the institutions within which they train. Consequently, even given the existence of a legislating/controlling body, with curriculum development plans beyond and wider than immediate service needs (as might be seen in the extension of the training syllabus and the introduction of subjects such as sociology, psychology, physics and chemistry), students are strongly influenced by their service role. Likewise, matrons, by virtue of their position as head of service, must give precedence to service needs. In Ireland, as in the United Kingdom the State controls nursing. In both countries the same Act of 1919 allowed control through a General Nursing Council, a body dominated by matrons and responsive to staffing and service needs of hospitals. In the United Kingdom, training and indeed nursing work became totally service - and indirectly doctor-oriented, as nursing work was subjected to the service of medicine in the hospital structure (Fretwell, 1978, p.11). Ireland is no exception in that nurses have never gained complete control of nursing, the State retaining this prerogative and exercising its control through the Nursing Board (An Bord Altranais 1950) as laid out in the Nurses Acts 1950 and 1961, and recently replaced by the Nurses Act (1985).

The new Nursing Board compilation shifts the matron's domination of nurse training but the composition remains heavily biased in favour of service, with only seven members directly involved in education (five of them nurses) on the Board. Nurses elect seventeen of the twenty nine member board. In Ireland, unlike the United Kingdom, service also dominates the hospital training school very directly, as the matron and not the principal

tutor is communicated with as head of the training school. Although both matron and principal tutor sign students' examination candidature forms (see appendix V1C), it is matron and not the tutor to whom examination papers are sent. It is as though educationalists per se are not a significant feature of Irish nurse training, and tutors themselves come under the rubric of service. No upward mobility or room for initiative exists for senior tutors; their only avenue of promotion is to return to the service side. Leydon (1980, p. 95) notes the ambiguous position of the tutor in Irish nurse training when she writes: "...the post of principal nurse tutor created less than a decade ago, still carries very little authority." In the United Kingdom a career structure exists for tutors, yet Alexander (1982, p.63) in a Scottish study writes of the situation of tutors: "They are generalists, 'maids of all work', required in most cases, to teach all or most of the subjects in the syllabus." The Commission on Nursing Education (R.C.N., 1985, 1.11, p.10) describes the poor conditions of service for tutors suggesting that nursing education is "imprisoned, in the trap of its own history". In a very real way, educationalists do not have significant control over the transmission of nursing theory. In Ireland, matron, the service head, is also head of education. Service needs and education needs do not always coincide especially in the short term: for example, from the educationalist's point of view it may be important for students to understand a procedure before performing it, whilst from the point of view of service it may be more important for a task to be performed before understanding is complete - the need for workers being more urgent than the perceived need for learning or teaching. As indicated, Melia (1981), amongst others suggests these gaps between theory and practice. Both in Britain and Ireland it seems that theory fails to make any real impact on care, and hence models of practice and indeed health education are neglected.

Professionalization

A strong nursing leadership may espouse a nursing theory based on a model of total patient care and incorporating a health education role, but for the present in Ireland, medicine is the point of reference for nursing leaders and students. The Working Party Report (1980) makes no attempt to question this immersion in a medical model. At a theoretical level, the focus of nursing is changing. This is evident from papers in international journals and nursing textbooks, and in Ireland is seen in the Working Party Report's (1980) definition of nursing, in the introduction of the Nursing Process and an individualized approach to care. The Working Party Report (1980) recognises that theory and reality do not always correspond and that task-orientation is the main method of delivering care in Irish hospitals. It seems as though, in line with E.E.C. directives, the Irish training syllabus attempts to provide a broader base for practice but makes little impact at that level. Apart from the small number of degree courses in existence in the United Kingdom, systems of training are similar to that in Ireland in respect of the student's role in the hospital workforce and the 'block' system of training (9, 10). The modular system of training is well established in the United Kingdom and the focus in nursing examinations is changing. In Ireland, a modular system of training, while recommended, has yet to be implemented (Working Party Report, 1980). Similar problems exist in the clinical setting for the British and Irish nurse, for example, theory-practice gaps are reported in the literature for both countries (Fretwell, 1982; Clinton, 1981; Bendall, 1975; Working Party Report, 1980; MacGowan, 1979). Underlying the expansion of nursing theory is the occupational elites' drive for professional autonomy. In both countries, nursing leaders are in agreement that professionalization, with resultant autonomy, should be an aim for the occupation, an aim which they are agreed can be achieved through the development of research-based practice. Both accept broad and all-

encompassing definitions of the nursing role, recognising both the diversity of the role and general trends in health care towards the extension of preventive care and primary health care. Latterly, however, divergences in thinking between the two countries have become apparent with the advent of two recent reports in the United Kingdom, namely the Project 2000 Report (U.K.C.C., 1986) and the report of the Commission on Nursing Education (R.C.N., 1985). The Working Party Report (1980, p.40) does not recommend that students should be free from nursing service, stating that "It is clear that the role of the student nurse can be neither wholly work nor wholly learning oriented." A situation is desired "where the student is able to perform both as a learner and as a member of the ward staff" (Ibid. p. 41). It accepts the student as learner and worker but with recommendations regarding a modular system of training and the setting of learning objectives in the clinical areas. In 1980, this Irish situation is quite removed from the recommendations of the Project 2000 Report (1986) and the Commission on Nursing Education (1985), both of which argue strongly for the removal of the student nurse from her service role, on the basis of the inadequacies of the student worker role in terms of ward teaching (Reid, 1985; Fretwell, 1982; Orton, 1981; Ogier, 1981) and in terms of future trends in health care provision. The Working Party Report (1980) recognises the same future trends in health care (11) but the recommendations for a modular system of training and a common basic training remain firmly within the medical model and indeed the acute hospital services. In recognition of a community care dimension, student nurses in Ireland receive one week's placement in the community and it is recommended that more registered general nurses are used to replace public health nurses for nursing work in the community so as to release public health nurses for preventive work (12). It also recommends the training of more public health nurses. The Report recognises trends in relation to

the expansion of community and preventive care but gives little emphasis to the development and expansion of general training from its encapsulation within the curative model. Chapman (1982) has suggested that if the nursing profession is serious about changing its focus from disease to health, then it should consider commencing basic training in the community setting.

The lack of adequate training and education has been identified by nursing leaders as resulting in a situation in which nurses fail to satisfy the criteria of professionalism. They recognise that nursing does not possess a unique theoretical body of knowledge since its knowledge base is still drawn largely from experience, thus the special area of nurses' competence is less well defined in comparison with that of other medical personnel. That nursing leaders aspire to professional status is evident from the drive by such nurses to make nursing work research based; it is linked very much with the development of nursing as a profession. Schlotfeldt (1977, p.4) writes:

> "The key predictor of nursing's eventual fulfilment of its potential as a socially significant, scientific, humanistic, learned profession is commitment to research."

The Working Party Report (1980, 3.6, p.30) states:

> "To be recognised as a profession, a discipline must have two main components; (i) it must offer a service to the community and (ii) it must have a body of knowledge unique to its function which it can apply in meeting needs. Nursing has justifiably acquired the status of a profession although there still remains a considerable area of knowledge to be explored and developed. The acquisition of nursing knowledge and expertise must be an on-going process; it must be scientifically based and research is therefore essential. At all times, the clear identity of nursing within the multidisciplinary health care team must be of vital concern."

This desire to increase research on nursing practice, thereby contributing to the nurse's accountability and responsibility is a prominent theme in nursing literature in recent years (Lelean, 1980; Hockey, 1979; McFarlane, 1980). In the nursing press it is rare for an issue to go by without at least one such article and some journals are almost entirely devoted to the

topic e.g. Nursing Research, Journal of Advanced Nursing and Nursing Review. Through establishing a knowledge base founded on research it is anticipated by nursing leaders that nursing will move further along the road to professional status. In the United Kingdom developments such as nursing research and degree based training are in embryo and it remains to be seen how successful they are. In Ireland these developments have yet to take place; the only nursing research appointment is that of Research Officer with the Nursing Board and the nurse tutors' diploma course has only latterly (1984) become a three year degree programme.

A development of nurses' health education function may be in keeping with nursing leaders' aspirations towards professional autonomy as nursing academics wish to expand the nurse's work beyond the doctor's area of control. In contrast, Reeder and Mauksch (1973, p.223), in relation to the suggested adoption of the physician's assistant role, clearly feel that the taking on of further rejected medical (technical) tasks will only serve to maintain the subordinate position of the nurse. Bowling (1980) in her study of delegation to nurses in general practice reports similar reservations. The Working Party Report (1980; 4.2.4; p.37) states:

> "The majority of the nurses engaged in the following activities accepted them as a normal responsibility and thus would seem to accept the concept of the extended role that is, the practising of higher technical skills by the nurse. The acceptable activities included:
>
> (1) Adding drugs to intravenous infusions;
> (2) Application of plaster of Paris;
> (3) Application of splints;
> (4) Setting up haemodialysis;
> (5) Suturing minor lacerations.
>
> The Working Party stresses the need for scientific study in this area to determine staff nurse work patterns throughout the country as a basis for future development of the nursing services."

The activities listed can be seen very obviously to be formerly medical tasks, tasks carried out by the physician and now to be carried out on his authority. The Working Party Report proposes no real change for the future

role of the nurse but rather suggests that future role be determined on the basis of existing practices and the fact that current practice is totally within and determined by medical practice is never questioned. Rather it proposes additional training of nurses in some technical aspects of their work to equip them to take on these rejected medical tasks. Degree courses and the development of a research basis for practice are both suggested in such a way that one may take them or leave them, thus reflecting the particular stage in development of professional aspirations and hence nursing practice in Ireland. Nursing in Ireland, while adopting a definition and approach to nursing that focuses on wider aspects of the caring role, remains firmly within a medical and indeed acute hospital care range of reference, when discussing aspects of the nursing role (Working Party Report,1980). Mention is made of a nursing role within the preventive field but from the general nurse training syllabus (An Bord Altranais 1979) and the recommendations of the Working Party Report (1980) it would be difficult to identify a nursing role in health education and most particularly, the role indicated by the World Health Organization, whereby the nurse facilitates the patient's understanding and the taking of responsibility for his own health. Such ideals are beginning to permeate British nursing (13), but despite a greater awareness and a greater willingness to experiment, as indicated in this chapter many problems still exist. Hockey (1980, p.909) has noted in relation to nurse training in the United Kingdom:

> "Some of the thinking potential seems to be supressed and we should welcome any educational programme which encourages thinking rather than inhibiting it."

SUMMARY

I suggest that this brief look at British and Irish nursing illustrates not simply differences but many similarities. Both British and Irish nurses encounter similar problems in the practice setting. Similarly, the changes that nurses in Ireland are espousing but have yet to develop (e.g. research into nursing, degree programmes, implementation of the nursing process <Working Party Report, 1980>) are those very areas which nurses in the United Kingdom are at present developing. After sixty eight years of state registration and sixty seven years of training for nurses it is a fact that the basis of nurse training has changed very little in Ireland. The deliberations that have taken place in recent years (The Working Party Committee on General Nursing 1980) have failed to question the assumptions underlying training, although making recommendations with regard to a number of areas, including the implementation of the nursing process, a common portal of entry to all trainings, a modular system of training, the need for research mindedness, the development of nursing research, and a degree programme for nurses. At the same time the Working Party Report (1980) seems to justify existing approaches to training appearing to indicate that all that is seen to be wrong stems from a lack of cohesion among schools, over reliance of some hospitals on student labour, and a lack of learning objectives in the clinical areas. The basic assumptions underlying training remain unquestioned, total encapsulation within the medical model is assumed and the only changes in this direction seem to arise because of E.E.C. directives. It is significant that the similarities between training now and training fifteen, forty or even sixty years ago strike one much more forcibly than do the differences.

The next chapter discusses the theoretical development of the study

as it examines approaches to the study of socialization locating and developing a perspective which would take account of all aspects of the student nurses' experiences in the hospital training school. Chapter 3 discusses the development of an appropriate research methodology and the course of the research. Chapter 4 begins the presentation of students' accounts of their initial contact with the hospital training school. Chapter 5 deals with students' experiences of life in the nurses' home. Chapter 6 examines both tutors' and students' experiences in the classroom, while chapter 7 focuses on students' experiences in the clinical areas. Chapter 8 includes a summary and discussion of findings. It indicates the importance of the methodological and theoretical approaches adopted in the study. The epilogue concludes the report with a discussion of the implications of findings for the nursing role in health education.

FOOTNOTES

1. To date in Ireland we have not entered into a 'specialist model' of health education, neither however are we within a totally 'integrated model' which simply gives existing health care professionals additional training (O'Doherty, 1978). What exists is in fact a 'compromise model' with some specialists emerging and some health professionals receiving training, scope exists within this model for nurses to accept responsibility to provide health education at a level of intervention appropriate to their work role.

2. The Working Party Report (1980) adopts a concept of nursing based on Maslow's hierarchy of needs and Henderson's fourteen primary components of nursing care. It adopts a nursing process approach to care (Working Party Report, 1980, pp. 29-31).

3. With a response rate of forty three per cent from student nurse centres and forty one per cent from pupil nurse centres, it indicated that less than half have a working definition which is available to all who teach and learn; while over half indicated that they integrate health education into all aspects of work, but little evidence existed to indicate how it was dealt with outside the classroom. Inconsistencies were noted in terms of assesment, seventy per cent of respondents considered health education was assessed with total patient care and sixty six per cent when ward management was being assessed. With regard to priorities health education occupied an

intermediate position and responses were evenly split between those who wished to enlarge the health education component in general training and those who did not. Health education in relation to the student's own lifestyle was assumed to be provided for in the teaching on disease and prevention for patients (Health Education Council, 1980).

4. It is only very recently (in Ireland) that health education by health personnel has been suggested at official level as being highly desirable. O'Dwyer (1984, p.2) states:

> "My basic assumption is that, just as most of the literature which discusses health promotion is written by people involved in health education, public health and primary health care, so most of the responsibility and effort for firmly placing health promotion on the national agenda must rest with those directing, managing and providing health services."

5. I suggest it may be more than an absence of skills and knowledge.

6. Nurses are represented on some hospital boards but have not as many seats as they would wish (Leydon, 1980, p.96).

7. This control of education by matrons in hospital may be seen as a throw-back to the Nightingale era and before the sixties when very often tutors had no particular educational expertise. The first tutors' course commenced in Ireland in 1960, though prior to that, a number of tutors had done a tutors' course outside the country. However, schools of nursing are no longer in the position of employing unqualified tutoring staff and most untrained tutors have retired. In 1984, a new three year full-time course for tutors started at University College Dublin,it awards a Bachelor of Nursing Studies Degree in Nursing Education on successful completion.

8. All general nurse training schools in the Republic of Ireland are located entirely within general hospitals and are service based. Recognised training schools in the country number twenty seven in all. Schools range in size from the large - with annual intakes of over one thousand students, to the small, with annual intakes of less than twenty. Intakes are twice a year (to suit service requirements), with ten to forty students in any one intake. Student nurses are service employees and are paid by their individual hospital except in recent times when, due to economic stringency, students have not been paid whilst in preliminary training school. They are paid on all other occasions whilst in 'block' (classroom) or on secondment for community experience etc., when they are free from work demands in their training hospital. Preliminary Training School consists of an initial 'block' of six to nine weeks in the school of nursing. Today in Ireland, out of a three year period (one hundred and fifty six weeks) for general nurse training, a total of twenty six weeks is spent in the classroom (block), a school which is very much part of the hospital structure, and the withdrawal of a 'set' (training group) from the wards for a few weeks can play havoc with duty rotas. Both intakes (sets) a year continue throughout their training to attend separate blocks (periods of classroom instruction). This means that lectures and all other teaching is repeated twice a year. The Working Party Report (1980) has recommended that this and State examinations be extended to three per year. One of the prime reasons for this duplication and lack of rationalization is the difficulty created in

ward staffing by the withdrawal of more than one set at a time from the work situation. As in the United Kingdom generally, a system of training exists in Ireland whereby student nurses are paid service employees.

9. Unlike the United Kingdom, nurse education in Ireland has escaped the imposition of a second tier of nursing with no provision for the training of enrolled nurses. A very small number of ward orderlies are to be found in training hospitals. Other differences exist in terms of recruitment and wastage, see appendix 1.

10. Compared with Britain, where five university departments of nursing exist, and with the United States of America where M.A.s and Ph.Ds in nursing are plentiful, Irish nursing while espousing some of the same nursing rhetoric has taken only a tentative step along this particular pathway.

11. A more preventive role and work in the community.

12. Health visitors or district nurses do not exist in Ireland, the equivalent grade being public health nurses who are trained to provide both preventive and curative care. They pursue a one year full-time course organized by The Nursing Board (An Bord Altranais).

13. For example, changes can be identified in British registration examination papers. In the past year, a number of nursing texts dealing with a nursing role in health education have been published (Ewles and Simnett, 1985; Coutts and Hardy, 1985).

CHAPTER 2

A THEORETICAL PERSPECTIVE ON THE PROCESS OF PROFESSIONAL TRAINING?

In chapter 1, a problem in nursing practice was identified whereby nurses failed to function as health educators and at a broader level nursing theory failed to make an impact on nursing care. It was suggested that as an initial step to understanding this problem an examination of the way in which the hospital training school transmits and promotes versions of nursing practice was necessary. This chapter discusses the development of a theoretical perspective which would consider this transmission and take account of all aspects of the student nurses' experiences in the hospital training school.

INTRODUCTION

The theoretical development of this study owes a debt to Newby (1975, 1979) and Berger and Luckmann (1967) as the following account illustrates. One of the foci for this present study arose out of my M.Sc. dissertation on 'Deference and the Training and Work of Hospital Nurses' (Treacy, 1979). That analysis of nurses' work and training was based on the writer's own observations of nurses' work and training and drew on published material in the field. Using Newby's (1975) concept of the 'deferential dialectic' as a framework of analysis, it was suggested that in many respects the nurse is an ideal type deferential worker. That paper (Treacy, 1979) examined the sexual division of labour that exists and is perpetuated within the hospital occupational structure, in the relations that exist between the male dominated medical profession and the female dominated nursing profession. The particular concern was with the nurse as a deferential worker, the operation of the 'deferential dialectic' and the management of

the tensions inherent in it. Newby (1975) puts forward the 'deferential dialectic' as a tool of analysis to explain the means by which elites maintain their traditional authority and the strategies they employ as they attempt to ensure the stability of their power. He has suggested that the origins of deference lie in the process of "legitimation by tradition of the hierarchical nature of the social structure by those in superordinate positions" (Ibid. p.146). This, says Newby, ensures the continuance of the power and privileges on which elites can continue to draw, but the deference of those at the base of traditional authority cannot be taken for granted. Therefore, strategies by which traditional elites legitimate their position are essential to our understanding of the social bases of deference and the stability of a hierarchical social structure. Newby (1975, p. 149) suggests that deference derives from power and explains how the allocation of power is stabilized. Deferential interaction consists of two opposing elements; those of identification and differentiation. Tension must be managed between these two opposing elements if the relationship is to be preserved.

This structural-interactional approach provided the theoretical framework for my earlier analysis of the position of the nurse in the hospital setting (Treacy, 1979). To examine the position of the nurse from this perspective it seemed necessary to consider the 'objective' reality of her life in the wider society and hospital, her position in the labour market and aspects of the wider structural background within which she functions, as well as examining the very specific community within which the nurse works and very often lives (1). It also pointed to the need to consider subjective reality in the type of interaction which took place between the nurse and her superordinate in the health care system, the physician. The earlier study (Treacy, 1979), placed nurse training in a context of relative powerlessness. Following Newby (1975) it suggested

that in nursing the origins of deference lay in the processes of traditional legitimation of a hierarchical social structure. It also suggested that interaction can contribute to the maintenance of the status quo as elements of identification and differentiation are used by superordinates to control subordinates. Newby (1975) suggests that tension management, between the opposing elements of differentiation and identification, is important if those in authority are to 'hold the ring' and that for this to be manageable a degree of ideological hegemony is necessary. That is, while elites attempt to retain the identification of those below them in the hierarchy, they must also operate mechanisms of social distancing to underlie their differentiation. The earlier study (Treacy, 1979) focused on an analysis of such mechanisms.

Newby (1975, 1979), in his analysis of the agricultural labourer as a deferential worker, had indicated the importance of wider structural arrangements in understanding deferential interaction. The importance of these interconnections was supported in my earlier study (Treacy, 1979) as it suggested that hospital interaction could only be made sense of, if understood in the context of existing structural arrangements of the hospital and society. That analysis created an awareness of the value of considering the various experiences of student nurses, and the context of those experiences, i.e. the objective and subjective reality of the nurse, in order to understand the training experience. The 'deferential dialectic' while indicating directions for study, would have provided too narrow a focus to be of further use for illuminating details of the experiences of student nurses undergoing general training. More emphasis was needed on subjective accounts of students. There was also the danger of imposing a plausible theory simply by virtue of its broadness. For this reason, as a mode of analysis it was rejected for this study although it had suggested the need for a theoretical perspective sensitive to the various facets of professional socialization and nurse socialization particularly.

The earlier study (Treacy, 1979), used Goffman's (1971B) work on deference and demeanour, which offers ways of analysing interaction in terms of ceremonial rules. Goffman (1971B) indicates the importance of interaction and has suggested that it is important to look at ceremonial rituals to understand how deference is conveyed. He adopts an approach different from Newby and he indicates two broad groupings of deference; avoidance rituals and presentational rituals. He suggests: "any society could be profitably studied as a system of deferential stand-off arrangements,..." (Goffman, 1971B, p. 481). Goffman (1971B) also states that such rules governing conduct between two individuals may be symmetrical or asymmetrical i.e. superordinates may have the 'right' to exercise certain familiarities which the subordinate is not allowed to reciprocate. For example, he notes, that hospital doctors tended to call nurses by their first name while nurses responded with 'polite' or 'formal' address. A consideration of such forms of deference in that earlier study (Treacy, 1979) also helped to form the perspective of the present study as it reinforced the need to consider the student nurse and her interaction with others in the hospital setting. Goffman (1968) has also considered institutional contexts and the relevance of this to the study of the hospital is discussed later in this chapter. At a theoretical level, 'the social construction of reality' approach of Berger and Luckmann (1967) also informed that earlier study (Treacy, 1979) as it noted that an individual's self-concept and social reality are obtained through primary socialization and are reinforced and supported by significant others. Berger and Luckmann (1967, p. 150) say that socialization is:

> "the comprehensive and consistent induction of an individual into the objective world of a society or a sector of it...Secondary socialization is any subsequent process that inducts an already socialized individual into new sectors of the objective world of his society."

Newby's (1979) study employed Berger and Luckmann's (1967) theoretical

framework as a basis for an analysis of socialization and social structure. Berger and Luckmann (1967, p. 184) suggest that answers to the question "who am I?" are socially predefined, being "subjectively and consistently confirmed in all significant social interaction." But they further suggest that:

> "The reality of everyday life is not, however, exhausted by these immediate presences, but embraces phenomena that are not present 'here and now'." (Ibid. p. 36)

On the importance of context in socialization, Berger and Luckmann (1967 p. 187) note:

> "Socialization always takes place in the context of a specific social structure. Not only its contents, but also its measures of 'success' have social-structural conditions and social-structural consequences. In other words, the macro-sociological or social-psychological analysis of phenomena of internalization must always have as its background a macro-sociological understanding of their structural aspects."

They define social structure as:

> "the sum total of these typifications and of the recurrent patterns of interaction established by means of them. As such, social structure is an essential element of the reality of everyday life." (Ibid. p. 48)

To summarize, Newby's (1975) deferential dialectic suggested that deferential interaction can only be understood in relation to a particular context, that is, a power relationship. This reinforces the necessity of considering structural factors if actions are to be placed in some context of meaning. At an empirical level, it also reinforced the emphasis that Berger and Luckmann attach to social structure when studying socialization, as it contributed to an understanding of the variety of factors affecting relations and interaction in the hospital. Dingwall's (1974A) study and theoretical contribution to the study of socialization, was influential in developing this perspective - his approach to socialization as the study of social organization is discussed later in this chapter. In relation to the problem (outlined in chapter 1) which was the focus for the present study, the foregoing constituted the author's starting point. It was considered

that only a study incorporating all of the student nurses' experiences in training would contribute to an understanding of the problem. Before the study was initiated it was a basic premise (following Dingwall, 1974A; Newby, 1975, 1979; Berger and Luckmann 1967; and Treacy 1979), that both the 'objective' and the 'subjective' reality of individuals are important if their experiences are to be understood. Within these experiences the individual has many choices, Berger and Luckmann (1967, p.149) state: "to be in society is to participate in its dialectic". Given this perspective and given that student nurses are both learners and workers, I was prompted to consider, albeit selectively, the ways in which student experiences have been examined in the fields of education and sociology.

THE HIDDEN CURRICULUM AND PROFESSIONAL SOCIALIZATION

Educationalists have considered the problems of transmission and outcome in education in terms of a hidden curriculum whilst sociologists have considered them in terms of professional socialization. Implicit in studies of occupational experiences (Melia, 1981; Fretwell, 1978, 1982) and professional socialization has been this idea of a hidden curriculum. Becker et al. (1976), in noting the importance of 'learning the ropes'in the case of trainee nursing assistants, indicate that priorities differ from ward to classroom and that the trainee soon learns this in 'learning the ropes' in a situation which provides little teaching in the conventional sense but many subtle cues which guide his developing understanding of what people on the floor, both staff and patients expect of him. They go on to suggest that "failure to 'learn the ropes' may preclude learning anything else" (Becker et al. 1976, p.35), and note that this kind of learning is rarely included in the ordinary school curriculum. Both sociologists of occupations and educationalists have addressed this problem in different ways. Sociologists have looked at process and outcome

in professional socialization whilst educationalists have considered the 'unconscious' learning process under the rubric of work on the hidden curriculum (an area much neglected in education) as they consider the effects of the informal curriculum. First, a brief look at the way in which educationalists have addressed the issue.

THE HIDDEN CURRICULUM

The hidden curriculum is a concept developed in work on education which directs attention to hidden aspects of schooling, those unanticipated, unplanned effects of education structures. Snyder's (1971) work suggests the importance of the informal curriculum in determining attitudes and promoting different types of behaviour and indicates the possible outcome for the student nurse of different types of socialization experiences. He states:

> "Students receive one set of official, formal messages - the rules, the prescriptions, the goals. In effect, these are what one must do to pass, to succeed, to move ahead from university to larger society. At the same time, the students are monitoring another more informal, covert set of areas that tell them what really matters - what in fact leads to rewards and success." (Ibid. p.126.)

Implicit in all of this is the notion of a hidden curriculum. The relationship to 'learning the ropes' (Becker et al. 1976) is apparent. Jenkins and Shipman (1976, p.17) note:

> "The hidden curriculum includes all those pervasive values that one is expected to acquire by a process of institutional seepage; things like punctuality, good behaviour, tolerance of frustration, loyalty. These and other influences on the individual come from his or her involvement in an organization with consistent assumptions as well as specific objectives, an elaborate set of expectations as well as a specific mode of working. Over time traditions and rituals are developed which reinforce the influence exerted over the individual."

In defining the hidden curriculum as all that is learned in addition to that which is on the official curriculum Meighan (1981, p.59) makes the point:

> "that defining the hidden curriculum as the form or framework of schooling as against the content of the official curriculum is too limiting in that it obscures the hidden aspects of the official curriculum and ignores the self-defeating processes such as an assessment system encouraging selective neglect of parts of the official curriculum in trading for grades."

In nurse training, one cannot ignore the experiences of ward life, life in the classroom or the assessment system whether of the wards or of the school, if one is to understand what is learnt as a student nurse. Work relationships, teaching methods and tutor-student relationships, ward reports, school of nursing tests, institutional experiences like 'living on-the-job' all convey messages of the hidden curriculum. Jackson (1968) suggests that the hidden curriculum is comprised of rules, routines and regulations and these must be learned by pupils if they are to cope successfully in classrooms; this would appear to be especially true for the student nurse who does not simply have to survive and feel reasonably comfortable in the classroom but must do so in the clinical areas as well. In a very general way this concept presents a focus for this study, as it suggests the importance of considering the messages implicit in the training experiences of student nurses. In occupational socialization and in nurse training the informal and formal curricula are both important.

Bernstein's (1971A) work on integrated and collected type curricula is illustrative of some of the ways a hidden curriculum may exist in one setting i.e. in the classroom. On the classification and framing of educational knowledge, Bernstein (1971A, p.47) says: "How a society selects, classifies, distributes transmits and evaluates the educational knowledge it considers to be public, reflects both the distribution of power and the principles of social control." He suggests that the study of socialization has been trivialised saying:

> "differences within and change in the organization, transmission and evaluation of educational knowledge should be a major area of sociological interest....Indeed, such a study is a part of the larger question of the structure and changes in the structure of

> cultural transmission. For various reasons, British sociologists have fought shy of this question. As a result, the sociology of education has been reduced to a series of input-output problems; the school has been transformed into a complex organization or people-processing institution; the study of socialization has been trivialised." (Ibid. p.47)

The work of Bernstein (1971A, 1975) increased awareness of potential message sources at a structural level in the hospital training school and most especially within the classroom. The existence of messages at this structural level are considered in chapter 6 - 'The Life of the School'.

PROFESSIONAL SOCIALIZATION

Professional socialization studies have also considered transmission and acquisition of occupational beliefs and attitudes with the implicit recognition of an informal agenda. Hughes (1956, p.22) writes:

> "The education of the members of the medical profession is a set of planned and unplanned experiences by which laymen, usually young and acquainted with the prevailing lay medical culture, become possessed of some part of the technical and scientific medical culture of the professions...Medical education becomes the learning of the more complicated reality on all these fronts."

Studies of occupational socialization can be identified as falling into two camps, the work of functionalists (Merton et al. 1957) and interactionists (Becker et al. 1961). Very simply, the functionalist approach focused on ways in which the professional role was acquired and students were seen as 'empty vessels to be filled'. Interactionism represented a challenge to the functionalist approach as it focused on the work of members and how students negotiated their way through professional socialization. Both Merton et al. and Becker et al. represent very different views of students. Simpson (1979), in addressing the problem of professional socialization studies indicates that in the past socialization studies have often studied different things but used the same global term of socialization. She identified the two main streams in socialization studies as follows:

> "The induction approach focuses on the acquisition of the professional role by students during professional education; it studies attitudes, values, and outlooks along with the skills and knowledge that constitute the professional role...The reaction approach looks at students but does not view them as acquiring a professional role. It looks at their identities and the commitments that sustain them during their professional education and motivate them to complete it and go on to professional practice. In contrast, the induction approach takes motivation for granted, not a subject of inquiry. The induction perspective sees students as being inducted into a role; the reaction perspective sees them reacting to educational experiences." (Ibid. p.4)

Therefore, to date professional socialization studies fall into two main categories (Simpson, 1979; Dingwall, 1974A, 1977). The perspectives of these studies differ in the way in which they view the subject of socialization. Induction approach studies (Merton et al. 1957), in the functionalist tradition, view students as passively and mechanistically moulded to the professional role, while reaction approaches (Becker et al. 1961; Olesen and Whittaker, 1968), see the students as actively participating in their own socialization experiences (2). Simpson suggests that, since the main variables studied by both are essential aspects of socialization, the two approaches need not be conflict. She states that both perspectives have contributed to our understanding of occupational socialization and attempts to develop a model to bridge the two perspectives. Simpson (1979, p.6) suggests that any study of socialization should incorporate a longitudinal approach, and advocates that the two most essential questions about socialization are: "...the development of cognitive sets and motivations and their persistence from one situation to another." She sees occupational socialization as being the imparting of skills and knowledge to do the work of an occupation, of orientations that inform behaviour in their professional role and, unlike adjustments to specific situation, they persist. She states:

> "Its persistence across status transitions and situational changes is one of its distinguishing features. Another is its generality." (Ibid. p.6)

Dingwall (1974A) has also reviewed acculturation and enculturation approaches to the study of socialization. He says that:

> "The acculturation model sees actors as working on their world to make sense of it and their passage as uneven, continuously problematic, individually paced and incomplete." (Ibid. p.40)

While the enculturation model suggests an absorption into a culture "rather than as negotiated exchange as a consequence of culture", it is suggested that such a perspective:

> "neglects the part of persons other than those designated as instructors in teaching students about the requirements of the task... <it> ...avoids any discussion of the students' location within the wider society and its culture." (Dingwall, 1974A, pp. 8-9)

Induction studies fail to go beyond taken-for-granted assumptions regarding the finished product whilst reaction studies, in adopting a perspective of active involvement, may imply a degree of control by the subject which I suggest may be dependent on a particular type of organizational context and consequently may not be apparent in some settings. That is, it highlights the existence of a student sub-culture but may assign such sub-cultures a role that may not be available to them because of structural arrangements. Olesen and Whittaker (1970, p.193), criticise much of the earlier studies of nurses for their failure to do other than conceptualize the student as a product, they state:

> "The broader view of professional socialization as acculturation, e.g. groups in contact and exchange, shapes certain themes in conceptual adequacy, one such being the individual's shift from one culture to another and their adjustment to this. The concept of 'student culture' used in studies of medical and nursing students allows analysis of this shift and, in addition raises questions concerning students ' emergent relationships and the learners' impact on the course of their own learning and the institution itself."

It is suggested that 'student culture' thus avoids the bracketing elements which intrude when professional socialization is thought of too narrowly as 'assimilation'. Olesen and Whittaker (1970) suggest that any socialization concept should guide, sensitizing to new ideas and hence lead to the

construction of theory. They suggest that three major themes inform adequacy, firstly, the meaningfulness to persons in everyday life, secondly, incorporation of the inner or subjective aspects and including interpretation of objective factors and thirdly, elucidation of change factors in the subject under consideration. Most induction and many reaction approach studies suggest, in varying degrees, an almost taken-for-granted assimilation into a taken-for-granted professional role. The context of 'assimilation' remains unquestioned. Dingwall (1974A, p. 40) criticises the use of the term socialization as it embodies passivity and being acted upon - he advocates instead the use of the term social organization to describe the process. He states:

> "Socialization is the acquisition of...(practices which consult the rules, policies, procedures and roles of the organisation of the setting to see what they might reasonably mean)...rather than any internalization of programming rules." (Ibid. p.21)

Dingwall (1974A) suggests that in the study of socialization into occupations it is necesssary to adopt a theoretical perspective which allows examination of the ways in which people engage in their everday life together "to impose sense upon that absurdity which is our social world." The following summarises Dingwall's (1982, p.10) approach:

> "While the interactionist position stresses the acquisition of negotiating skills and impression management techniques by students, this neo-ethnomethodological approach gives more weight to the inspection of students by staff who are concerned to document their own compliance with their organizational character and their competence as awarders of licenses."

This suggests a focus on significant others in the socialization process.

Studies of Nurses

I will now examine briefly aspects of studies of nurses relevant to this present study. Within this examination I have attempted to locate my own approach to the study of nurses relative to those other studies - they are set out in diagram form in Figure 1 (see appendix 11) and consideration is given to aims, methodology, perspective and theoretical assumptions. As can be seen, although all of these studies are within the acculturation

tradition they differ in aims, methods and perspective. Olesen and Whittaker (1968) represent the first major study of nurses within the acculturation tradition, yet, Dingwall (1974A) has noted how their methods may reinforce the enculturation perspective. Likewise, other deficiences are noted in their study. Olesen and Whittaker (1970, p.211) themselves concede, that their study did not concern itself sufficiently with staff activities. They also recognise the limitations of their questionnaire data without limiting the use of their data, Dingwall (1974A, p.24) states that: "This is most evident in the factual status which is accorded to the personality tests which were used." He suggests that Olesen and Whittaker (1968) also failed to take account of lateral life roles despite their own injunction and there is an over concentration on students as students as the institution becomes central to their lives. On the image of self assured, competent, articulate final students that comes across, Dingwall (1974A, p. 24) suggests that this may be an accurate reflection of their study institution but that other settings may be different, particularly in nursing given the variety of training experiences available. I share similar reservations.

Davis (1975) discusses doctrinal conversion and subjective experience in nursing and presents an account of movement from 'lay' to 'professional images', highlighting the student's active involvement in 'sussing out' the institutionally approved image before internalizing the perspectives of the professional nurse. However, Davis (1975) concerns himself simply with the student's subjective reality and the experience is not located within a social structure. Dingwall (1974A, p. 23) suggests that Olesen and Whittaker (1968), and Davis (1975):

> "present a model of students caught by soft determinism, as continually emergent out of confrontation between the person and the situation and occupying three modes of being, the inner world, the world of social relationships and the world of the environment...The proper topic of the sociologists enquiry is the lived in world of the students and the others whom they encounter,

the shared meanings which structure their everyday world."

Dingwall (1974A, p. 9) acknowledges the uncertainty of training when he states:

> "Training is eventful, uneven and continuously problematic for students. They are continually required to work out what they must know in order to pass out, to manage time and the relevance of their knowledge, ... and to maintain some kind of competence as a person in relation to the other people whom they encounter in their everyday lives."

In the United Kingdom, Dingwall, in his study of health visitors, has suggested a multi-dimensional approach to the study of socialization. He saw socialization as acculturation and suggests that his study "is about the social organization of the acquisition of competent membership" (Dingwall, 1974A, p. 40). He thereby suggests that adult socialization incorporates both objective and subjective experience of social life (Ibid. p. 9). In describing his study of health visitors, Dingwall notes how, as he adopted a quasi-student role, there was resultant exclusion from the everyday life of teachers and by his own account this represents a gap in his study. Simpson (1979, pp. 225-226), in summarizing the differences between functionalist and interactionist approaches also tries to integrate the two as she takes a multi-dimensional view of occupational socialization. She states:

> "Studies have used the concept globally, not recognising its multi-dimensional nature.
>
> Our study has attempted to clarify the concept of occupational socialization by specifying its multidimensionality. We have shown that it involves learning skills and knowledge of the occupation, developing orientations to occupational roles and to place in the occupation and relating the person to the occupation. Each dimension consists of distinct processes, and these were developed by different conditions."

Simpson goes on to say:

> "...not only do our findings argue for rethinking the nature of the process of socialization, they also suggest that conditions associated primarily with individual students will not enter significantly into the general pattern of equipping novices for occupational roles." (Ibid. p. 227)

The persistence of change is seen as important in socialization, Simpson's

study is mainly concerned with measuring and recording changes in students, as this predominates, little insight is offered into the subjective experience of becoming a nurse. Also, as with much early work on socialization, definitions used are the faculty staff's and not the students. Faculty staff helped to compile the questionnaire and selected students for interview on the basis of the faculty's classification of best, average or poorest. Simpson (1979, p. 48) notes that their original framework for the research closely followed the induction model of socialization and, although she extends her view of socialization, she suggests that the design of the study anticipated many of the measurement issues raised. Although the study is important in its scope and emphasis on the multi-dimensionality of socialization (both faculty staff and parents received questionnaires) - the study simply gives insight into how the students meet faculty's requirements. In its concern to measure change, it fails to bring together subjective and objective experience in professional socialization.

While recognising the place of the longitudinal study in professional socialization research, this present study differs from Simpson's not simply in its cross-sectional approach but in its aims. Simpson attempted to study cognitive changes and to measure their persistence over time, she attempted to identify the development of orientations and the persistence of consistent reactions. This study, which focuses on students' first hand accounts, attempts to understand training as a lived experience, rather than being concerned with 'final' outcomes. The question regarding persistence or change is not asked in this study, as it is suggested that the first step in studies of professional socialization is to understand the experience. This study examines students' responses to their current training programme.

Maguire's (1969) review and Dingwall (1974A, p. 8; 1974B) indicate many

of the deficits of earlier studies of nurses in the United Kingdom. Conway's (1984) review of nurse socialization studies is indicative of gaps in nurse socialization studies in the United States; the criticisms made by Olesen and Whittaker (1968, p.6) hold also for most of those studies as they illustrate "...before-after designs, instruments to measure amount of role or value acquisition, and tests to assess the contours of a 'true professional'." Olesen and Whittaker (1968) suggest that such research enterprises are non-productive as they are not related to the experiences of students and faculty in professional socialization.

Melia (1981) employs grounded theory in her study of student nurses, and incorporates something of the 'tradition' explicated in Dingwall's (1974A) study. She does not claim to present a socialization study as such, but seeks "to explore the student view of nursing through the analysis of students' accounts of their experiences" and the study "takes a detailed look at how the students themselves, describe their world" (Melia, 1981, p.19). Melia's study does not directly incorporate wider aspects of socialization e.g. the views of significant others and the organizational context. Like Olesen and Whittaker's (1968) study and to a much lesser extent Dingwall's (1974A, 1977), it is very much the student's side of the story but makes no claims to be otherwise. Melia's study considers subjective reality and does not incorporate the objective reality of ward and school of nursing life. However, it presents some very interesting aspects of student experiences and these are discussed further in chapter 7. In relation to his study of health visitors, Dingwall (1982, pp.8-9) states:

> "For the most part, members operated within legitimated modes of action without ever needing to reflect or elaborate upon the basis of that legitimation. The occasions on which such reflection does take place are rare and unrepresentative of the mundane reality of everyday practice. At the same time, if one does concentrate purely on everyday practice, especially among lower-level personnel, then one is in danger of missing the co-ordinating and disciplinary devices which bind their action together."

Here Dingwall (1982) is indicating the necessity for wider study within an organization. Atkinson and Hammersley (1983, p. 175) suggest that there is a danger as "the naturalistic commitment to 'tell it like it is' tends to force the process of analysis to remain implicit and underdeveloped." I do not wish to suggest that Melia's study represents Lofland's (1970 - cited in Atkinson and Hammersley 1983) 'analytic interruptus', however it is but a step towards the development of theory.

A MODEL FOR THE STUDY OF NURSE SOCIALIZATION

This consideration of existing work is the backdrop for the present study. Bearing in mind Newby's (1975, 1979) work on the deferential dialectic, Berger and Luckmann's (1967) 'social construction of reality' approach, the application of these in Treacy (1979), and Dingwall's (1974A) approach to the "acquisition of the professional role" as the social organization of health visitor training, this study attempts, at an empirical level, to take account of wider and more recently raised issues in professional socialization. Writers on socialization have been criticised for their acceptance of the "insulation of the socialization experience" (Atkinson 1983). Dingwall (1982, p.2) says:

> "Atkinson...stresses the need to look at the organizational struggles which give material reality to the legitimation of specific selections from the universe of possible knowledge. If we are to do this, though, we may need to develop a form of analysis which lies closer to the everyday activities of socializing institutions. More precisely, we may need to improve on previous work not merely by incorporating a perspective of knowledge but also by improving on basic conceptions of the training organizations themselves, in the process absorbing Atkinson's other challenge to the body of literature for its insulation in the socialization experience."

Like Berger and Luckmann, Atkinson (1983) indicates that context is important in socialization. He suggests that neither functionalist nor interactionist writers on socialization have addressed the problem of knowledge, as they have treated professions in an unproblematic way. He

suggests the need for a concern with the latent functions of the hidden curriculum and indicates that perspectives for the study of professional socialization are available from the sociology of knowledge in the field of education. He further suggests that lessons may be learned from Bernstein's (1971A, p. 47) imperative to study: "How a society selects, classifies, distributes, transmits and evaluates the educational knowledge it considers to be public." Implicit in Atkinson's suggestion is the approach to socialization of Berger and Luckmann, which suggests the importance of context. However, Atkinson makes a very specific suggestion in terms of drawing on the sociology of knowledge in the field of education, and the consideration of structural aspects of the educational process. As indicated at the beginning of this chapter, the importance of structural features of educational transmission had been suggested and Bernstein's (1971A) analytical framework of codes and control has been reserved as a possible mode of analysis. However, as suggested at the beginning of this chapter, other social structural factors may be important in socialization. These can only be considered in the light of specific contexts. Becker et al. (1961), in their study, recognise the importance of such context when they note the power that faculty and administration have and the control that they can exercise over students' activities. Depending on the extent of power activated by the faculty, they suggest that students may have no choice other than simply to adopt faculty ideas and perspectives. But they omit to highlight the alternatives as suggested by Lacey (1977, p.67) i.e. strategic compliance, and they fail to give an account of the way in which such values can be made to seem all pervasive. An account is needed of the ways in which ideological and moral hegemony may be achieved, and context cannot be dismissed if such an account is to be presented. Atkinson criticises Becker (1972) for dismissing one context as Becker states on the effects of schooling:

"school is a lousy place to learn in".

Thorner (1955) has suggested that given their immersion in the hospital milieu the degree of socialization for doctors and nurses differs from that of other professional groups. However, on the basis of my previous study, I go further than this and suggest that for the student nurse, socialization is likely to be a far more 'intensive' experience than for the medical student. At this cursory level it is suggested that structural arrangements e.g. the type of residential demands made in nursing result in particular controls of student nurses' life and behaviour. Although both medical students and student nurses experience the life of the hospital, there are sharp divergences particularly in relation to control of behaviour and possible life-style (Treacy, 1979). While the medical student 'plays' at doctoring, the student nurse works in a bureaucratic organization providing 'real' service. It is the knowledge of these very real and unique differences in the socialization of the student nurse that leads the writer to also raise a question as to the accuracy of a model of socialization which implicitly views the subject as a 'free floating agent' regardless of context. As Coser (1961, p. 39) suggests, physical space as well as social spaces gives man his identity.

The Importance of Context in Socialization

At a theoretical level, Berger and Luckmann suggest that, for socialization to be successful, a high degree of symmetry between subjective and objective reality is necessary (3) and 'unsuccessful socialization' should be seen in terms of 'asymmetry between objective and subjective reality'. They note that heterogeneity in socializing personnel may also result in unsuccessful socialization, as a number of influences are available (Berger and Luckmann, 1967, p. 187). A paper by Bucher and Strauss (1961) further supports the acculturation perspective as it suggests ways in which a range of choices may be presented in the

various segments of the profession, and thus indicates the potential for a variety of outcomes in any socialization experience. Berger and Luckmann (1967, p. 183) state:

> "Maximal success in socialization is likely to occur in societies with very simple division of labour and minimal distribution of knowledge."

It is suggested that, under such circumstances, socialization produces conditions whereby every individual is presented with basically the same institutional programme for his career in the society. Thus Berger and Luckmann (1967, p. 184) state:

> "...the total force of the institutional order is brought to bear with more or less weight on each individual, producing a compelling massivity for the objective reality to be internalized."

Few interpretive studies, apart from Lacey (1977), consider the concept of power in relation to professionalisation. Lacey (1977, p. 20) suggests that a conflict model is relevant in socialization as: "Conflict between groups and within groups is likely to make socialization less straightforward in many ways." He is therefore, suggesting the importance of context. Lacey's work, with its suggestion of relative power and the wider context within which socialization takes place, must indicate the need to widen the scope of those other interpretive studies.

Religious institutions deal with the problem of socialization by dispensing with the past self, as do other 'total institutions' (Goffman 1968) thus indicating how structural features can contribute to socialization. Dornbursch (1955) illustrates such socialization experiences for the military cadet. Institutions requiring a high degree of commitment from their members, and most especially new members, may attempt to dispense with past identity by the creation of a 'total institution' and substitution of a new code by which to live. At a theoretical level, Berger and Luckmann recognise that such conditions cannot always be easily created requiring as they do, the means i.e. the authority, to control and

discipline.

These types of socialization experiences may more usefully be viewed as re-socialization than as secondary socialization in order to clarify and contrast differences, as indicated in Figure 2.

Figure 2

Re-Socialization	and	Secondary Socialization
The past is reinterpreted to conform to the present reality (no real account is taken of the past). Past experience cannot be used to make sense of the present.		There is a certain consistency with previous reality and identity. The present is interpreted to stand in a continuous relationship with the past.

(Based on Berger and Luckmann, 1967, p. 182)

Berger and Luckmann (1967, p.179) state:

> "The most important conceptual requirement for alteration is the availability of a legitimacy apparatus for the whole sequence of transformation."

The 'concept' of the 'total institution' gives some indication of the totality of any socialization experience or, rather, the possibility of its totality. In this respect, Goffman's (1968) discussion of totalistic features provides a framework within which to analyse institutions; he describes the central feature as the breakdown of barriers ordinarily separating the spheres for working, sleeping and playing. These are discussed more fully as they relate to the data presented in chapters 4 and 5 and assist in the analysis of the organizational context of nurse training. Millham et al. (1975B), in a consideration of socialization into residential communities ,point out that in different systems, approaches to socialization may differ, for example, in the socialization experience in a public progressive school. The institutional control (although in

this case exercised by peers), may be equally as severe in its regulations as in a public traditional school and indeed its values less open to manipulation by staff.

This, I suggest, implicitly recognises the existence of a hidden agenda. Such work also points to the need to distinguish between the formal and informal social system and the need to view the wider social system in which socialization takes place. It indicates the need for awareness of a hidden agenda. Millham et al. (1975B, p.239) indicate that:

> "The need for the stripping of privacy, public living and scrutiny, expressive rewards and an awareness of your own and others authority can be understood only when the wider functions and aims of the schools are considered."

and Tizard et al. suggest that Sinclair (1975) indicates:

> "The extent of a staff member's influence and the qualities he needs to exercise it properly depend on the organizational context in which he works."

Tizard et al. (1975) indicate that there is a need to describe determining features of institutional life and to see how they influence behaviour and development. They point out that: "...staff perform within the constraints imposed by their organizational setting" (Ibid. p.10). In such cases, at a theoretical level Berger and Luckmann (1967) suggest that objective reality may not coincide with subjective reality. This indicates the need to consider constraints experienced by all in the institutional setting. Given such recommendations it would seem foolhardy to ignore the wider organizational context within which the individual is socialized. In keeping also with reaction approach studies of socialization Millham et al. (1975A, p.203) state that Etzioni and others suggest:

> "...that behaviour is role-determined and that the individual is on automation programmed to respond mechanically to the demands of the organisational structure, be he a teacher, a student or a worker. This does not accord with what is clearly observable in complex organisations and much recent sociology now stresses the ways in which individuals and groups within the organization perceive, evaluate and react to their social situation. Particularly influential here have been the works of Mead (1934) and Berger and Luckmann (1967) who suggest that an individual's behaviour is not simply determined by outside forces or evoked by

> internal impulses...but results from his interaction with others. Their perspectives suggest that a member of any organization defines and evaluates his situation and that this is an important factor in determining behaviour. He does not simply respond to social pressures in the manner of some robot."

Millham et al. (1975A, p. 209) describe the formal social system as that institutional structure developed to ensure the achievement of specific goals. They suggest that a whole variety of controls exist, within an institutional setting. These are controls over activity, relationships, possessions, time, movement and privacy, thus reflecting a Goffmanian (1968) concept of totality. They note also the existence in institutions of "signposts to correct behaviour" in the rituals, competition, activities allowed and distribution of time and resources. Millham et al. (1975A, p. 212) state: "All of these continuously delineate and remind staff and other inmates of the goal priorities of the organisation." The degree of control possible is also dependent on pre-socialization experiences and dependence on the institution. Millham et al. (1975A, p. 212) note:

> "The extent to which inmates view certain control processes as legitimate will vary with their presocialization and their depending on the institution to meet a variety of needs. Where inmates are less dependent on the institution, such as in prison, social control can rely less upon expectations and has to employ a system of privileges, sanctions, rewards and institutional control in order to maintain the desired levels of discipline."

In the case of nurse socialization, such an approach enjoins the consideration of the institutional controls in terms of reward and sanctions on behaviour. For my own approach to this study it suggested a need to collect information on how the student nurse and significant others experience and perceive such institutional arrangements.

The foregoing constitutes the writers' perspective at the commencement of this study. It is an account which attempts to recognise the researcher's inability to be atheoretical or theoretically value-free but the account is also presented to inform the reader, in a very general way, of the knowledge and issues which seemed relevant to the study. Without ignoring relevant theoretical contributions, the study moved into a more

'data driven' mode. To reflect this, data on the whole are presented first, followed by a discussion of relevant theory. Thus an open theoretical approach was maintained and in keeping with this a qualitative methodology constituted the thrust of the study (see ch. 3).

A GROUNDED THEORY APPROACH

Glaser and Strauss (1967) suggest that the logico-deductive theorists did not use data for generating theory, but supported quantitative verifications as the best way to formulate and modify their theories without mentioning the lost emphasis on generating theories. Glaser and Strauss (1967, p. 18) state that both qualitative and quantitative forms of data are necessary but suggest that, as sociologists concentrated on modifying or reformulating existing theories, there was loss of potential theoretical sensitivity because the sociologist was committing himself exclusively to one preconceived theory and in doing so became dogmatic, no longer being able to see around either his pet theory or any other. They state that the main purpose in using qualitative research is to generate theory, not to establish 'verifications with the facts'. They indicate the danger of structured research design as follows:

> "By contrast, data collected according to a pre-planned routine are more likely to force the analyst into irrelevant directions and harmful pitfalls. He may discover unanticipated contingencies in his respondents in the library and in the field, but is unable to adjust his collection procedures or even redesign his whole project. In accordance with the conventional practice, the researcher is admonished to stick to his prescribed research design, no matter how poor the data." (Ibid. pp. 48-49)

In developing grounded theory the emerging theory will point to the next step. The sociologist would not be able to anticipate these in advance as he is guided by the emerging gaps in his theory and by research questions presented by material already collected. Cicourel (1964, p. 2) has criticised quantitative methods on the basis that they represent the imposition of numerical procedures that are "external to the observable

social world, empirically described by sociologists and the conceptualisations based upon these descriptions." This is not the extreme position it may seem, he points out. What he seeks is clarification of sociological equivalence classes at the level of basic and substantive theory, not 'better' measurement systems.

Melia (1981), in her study of general nursing students used a grounded theory approach allowing data to generate concepts. Her aim was to describe training from the viewpoint of those studied. The present study differs from Melia's, as it uses a variety of methods for data collection, and attempts to focus on all aspects of students' lives. The study, while suggesting a particular perspective on socialization, triangulates method throughout and with the benefit of hindsight, one can say that it also triangulates at a theoretical level (see pp. 290-2). Atkinson and Hammersley (1983, p. 24) note:

> "The multi-stranded character of ethnography provides the basis for triangulation in which data of different kinds can be systematically compared."

Melia, in describing nursing research methods, describes the case of "the methodological tail wagging the substantive dog" and the same can be said of some sociological research but it should be noted that the theoretical tail may also wag the dog. It is for this reason that theoretical frameworks were not applied in the course of data collection but rather considered in the light of findings. It is in this sense that the grounded theory approach of Glaser and Strauss informed and directed the study (4); with resultant working back and forth between data and an open mind kept on the applicability of theoretical models. Atkinson and Hammersley (1983, p. 23) state: "The value of ethnography is perhaps most obvious in relation to the development of theory", its portrayal of the "activities and perspectives of actors" and the consequent questioning of the social scientists' preconceptions.

In this study, I attempt to describe what is going on in nurse training, how the student nurse experiences what is going on and how she feels about training. Given this particular interest, that of attempting to describe training from the student's point of view it was clear that the methods of choice for this ethnography should concentrate on observing students at work, in the school of nursing and also obtain information from them with regard to their experiences of nursing. Dingwall (1977, p.13) states:

> "The principal feature of the interpretive approach is that social interaction is to be understood as the construct of processes by which actors and observers make sense out of what has taken place and use this interpretation as grounds for ordering their own actions."

This present study could best be considered as concerned with the student perspective rather than student nurse socialization. Reid (1983, p. 9) states: "The only way to understand the student experience is to focus on the student...the only tangible means of assessing output of a ward as a teaching area is to focus on the learner."

THE RELATIONSHIP OF THEORY and METHOD

A number of writers (Fay, 1975; Dingwall, 1974A and more recently Atkinson and Hammersley,1983) have noted how social theory and practice are interrelated. They suggest that both positivist and interpretivist sociology have inbuilt assumptions about approaches to the study of the social world and that a neutral epistemology from which to view the world is not possible. In effect, what they are writing about is the interrelationship of theory and method. So often in sociology, theory and method are treated as separate topics, so that we get textbooks on social theory or research methods but rarely get texts or courses linking the two.

A 'neo-ethnomethodological' approach is adopted by Dingwall (1974A) in his study of health visitors. Ethnomethodology focuses attention on the

study of everyday life as it maintains that the social order has no existence independent of the members' accounting and describing practices. The researcher's model of the actor must rest on the interpretive procedures common to both the actor's and observer's methods for evaluating and generating appropriate courses of action. Thus, important features of ethnomethodological work are indexicality and reflexivity. Indexical refers to the context-bound character of interpretation, i.e. our interpretation of a phenomena depends on the context of its occurrence. This implies that the process of explanation is synonymous with the construction of social reality (Filmer et al. 1972). For ethnomethodologists sociology must be reflexive (positivism is seen as unreflexive speech). This study, like Dingwall's (1974A) and Melia's (1981), is an ethnography informed by the ethnomethodological approach, in terms of the emphasis given to the everyday experiences in the life of the student, it is directed by ethnomethodological considerations on the importance of subjective experiences. Atkinson and Hammersley (1983, p. 25) suggest that:

> "Neither positivism nor naturalism provides an adequate framework for social research. Both neglect its fundamental reflexivity, the fact that we are part of the social world we study, and that there is no escape from reliance on common-sense knowledge and on common-sense methods of investigation... We act in the social world and yet are able to reflect upon ourselves and our actions as objects in that world."

Spradley (1980, p. 13) suggests that ethnography offers an excellent strategy for discovering grounded theory. He states that ethnography

> "..seeks to build a systematic understanding of all human cultures from the perspectives of those who have learned them."

The interpretive method, which informed my perspective, leans towards building understanding in this way. Reaction perspective studies of socialization have all claimed to be working under an interpretive paradigm. In presenting this ethnographic account of training, its central

aim is to understand another way of life from the native point of view. The goal is, in Malinowski's words, "to grasp the native's point of view, his relation to life, to realise his vision of his world" (cited in Spradley, 1980, p. 3). It is then a discovery of insiders' views, not in terms of our definitions, but in their terms, how they identify and label things. But as indicated earlier in this chapter an understanding of objective reality is also important. Observation of the culture is necessary. Spradley (1980, p. 12) says that every ethnographer makes use of what people say in seeking to describe their culture. "Both explicit and tacit cultural knowledge are revealed through speech whether in casual comments or lengthy interviews." The theoretical perspective and aims of the study directly determined methods of investigation. The theoretical perspective as outlined, was broad, theory was not imposed in the data collecting stage. Wright Mills (1970, p. 233), writing on intellectual craftmanship, advises the sociologist to "cling to...vague images and notions.." and work them out. "For it is in such forms that original ideas, if any, almost always first appear." He further states:

> "Let every man be his own methodologist: let every man be his own theorist: let theory and method again become part of the practice of the craft."

Eldridge (1973, p. 279) says this remark was aimed at preventing intellectual stagnation in terms of

> "slavishly following certain established procedures of investigation or of following unreflectively a received theory without proper regard to the problem in hand."

If theory and method are to liberate rather than constrain, if they are to aid understanding and interpretion, if Wright Mills' advice is to be taken seriously, then a flexibility of method is crucial. Wright Mills' injunction suggests the importance of a flexibility of method in the study of under researched areas. The desirability of keeping an open theoretical framework so as to discover not so much new theories but, as Bernstein

(1971B, p. 17) suggests new ways of looking so as to bring about a change in perspective and to promote new or better ways of understanding (see p. 293). This study attempts to be both data and theory driven (theory driven in the sense of the writer not being atheoretical and being aware of the possible relevance of theory) as it attempts to shed new light on the training experiences of student nurses.

As indicated, theory and method are interrelated; and the theoretical perspective, outlined in this chapter with its sets of assumptions, suggests a particular methodology which would locate student nurses' experiences. The writer's very general theoretical concerns are represented in a particular choice of methods. Methods, which as the theoretical framework suggests, allow subjects' experiences to be made manifest. Given the nature of the research question, this open approach was considered the most appropriate for this particular study. As part of that ethnomethodological perspective, Cicourel (1964) notes that any reference to the actor's perspective must cover both the researcher's and the actor's attempts to negotiate field work and everyday activities (5). This chapter concludes with a discussion of guiding principles in the design of the study, research questions are indicated elsewhere (see p. 65). This study takes the view that the subjective experience of students is crucial to understanding aspects of their socialization experiences. I am not concerned as Simpson (1979) was, with how much students' attitudes, values, etc. change, rather with how they feel and what they experience as they go through training. This initial one dimensional focus was widened as it became clear that in order to understand the experience other data were necessary. These included the context of interactional classroom experiences, views of significant others and the context of ward work. In other words what became apparent was that if this study was to do more than highlight a problem, it had to consider the context. This is why interviews were also conducted with trained staff; and participant

observation took place on wards and in the school of nursing (6).

SUMMARY

To summarize, this study along with many others (Olesen and Whittaker, 1968; Dingwall, 1974A; Melia, 1981; to name but a few) views socialization as acculturation rather than enculturation. Olesen and Whittaker (1968) tried to understand how students accommodate and integrate multiple facets of roles and selves, whilst Dingwall (1974A) presented an account of 'how what passed as health visitor knowledge' was transmitted. Melia's (1981) ethnography, concentrated on student nurses' accounts of their work and training. This study and those others, operate with a perspective of the active participation of students in their own training - the alternative to the 'empty vessel to be filled approach' in nurse socialization. However, only Dingwall (1974A) attempts to take account of messages transmitted in the course of training, in other studies the modes of transmission and structural aspects of socialization are on the whole ignored. Atkinson (1983) points out the need for professional socialization studies to consider theoretical developments in the sociology of knowledge and in so doing to consider structural aspects of the educational process (7). This study remains within the acculturation and neo-ethnomethodological approach of Dingwall (1974A), but differs with regard to the consideration given to the way in which structural factors may affect experiences. At an empirical level it attempts a wider consideration of students' experiences within the hospital training school. A number of principles which emerged from my perspective guided the study and are summarized as follows:

1. The main focus for the study must be the student nurse as she recounts her experiences.
2. Interaction is important in shaping student experiences (Goffman 1956). Some of the effects of interaction with significant others have

been discussed elsewhere (Treacy 1979).

3. Studying students or inmates only, inevitably means, that only part of the institution is being studied. To understand more fully, experiences of significant others must also be a focus in the study.

4. As they progress through training students experience constraints or are exposed to images which affect the way they can live their lives whilst students. This is not to suggest that student nurses totally internalise enforced images, as Lacey(1977) suggests strategic compliance may take place. But the institutional context (the hospital culture) within which training is organised and administered is important to one's understanding of students' experiences.

This study attempts to widen the scope of approaches to the study of socialization. Incorporating Atkinson's (1983) advice it considers structural features of transmission, and experiences of significant others as well as the experiences of student nurses themselves. To this end it incorporates the study of both subjective and objective reality into the study of professional socialization. It attempts to understand the experiences of student nurses' in the institution in which they train and work and it attempts to locate their experiences as it considers a 'hidden curriculum' of the general hospital training school. It must be reiterated that a theoretical model was not imposed in the process of data collection or data assembly. Where, in the course of presenting and arranging the data, a theoretical model assisted in analysis this is indicated in the discussion which follows that section. Chapter 3 presents an outline of the research design of the study. In keeping with ideas of reflexivity and in order to reflect the research process as accurately as possible, some details of my day-to-day experiences in the role of researcher are included.

FOOTNOTES

1. Such was the scope of Newby's (1979) study of agricultural workers and Bell and Newby (1973).

2. Although Becker et al. (1961) have been accused of determinism by Lacey (1977).

3. Suggesting that totally successful socialization is anthropologically impossible.

4. In presenting such an open theoretical approach I see this study as very much a preliminary to further study of nurse socialization.

5. To this end, chapter 3 deals with methods of study, the researchers' biography, the problems of gaining access to the study areas and roles adopted in the course of interviewing and observation.

6. Implicit in this was the need for socialization studies to take account of objective reality.

7. The overall approach to this study owes much to the work of Dingwall (1974A). As a study it was returned to again and again and gradually permeated my consciousness. While not claiming to reproduce that type of study, my debt to the work is large.

CHAPTER 3

ACCOUNTING FOR STUDENTS' EXPERIENCES IN TRAINING: A FIELDWORK METHODOLOGY

INTRODUCTION

My theoretical perspective, as outlined in chapter 2, indicated the need for a qualitative approach to the study of student nurses. A number of guiding principles emerged from the theoretical perspectives (p. 63) and these were translated into the following interrelated research questions:

1. What is the student nurse's experience of life in the classroom?
2. What is ward life like for student nurses?
3. How is residential life experienced by student nurses?
4. What are significant others' views of training and expectations of students?
5. What is the context within which experiences and expectations occurred, and what are the overall effects of this context.

These questions are logically interrelated as they represent the awareness of the need to enquire into various facets of the student's experiences which go to make up the whole. As indicated in chapter 2 it is my contention that to fail to deal with any one of these is to ignore some aspect of nurse socialization and is therefore likely to result in an incomplete understanding of the process. The theoretical approach adopted advocates explication of methods and of the course of the research. This chapter also addresses these areas.

QUALITATIVE METHODOLOGY

In line with the aims of the study to describe and understand training from the point of view of the student, a variety of qualitative methods were employed to collect data. They included unstructured interviewing and

participant observation in wards and schools of nursing. A number of students and staff nurses also kept personal work diaries. Information was further supplemented by the collection of records, e.g. school time-tables and duty rotas. In short, material was collected from any source that would contribute to my understanding. All the information was collected over a fifteen month period excluding 'natural' breaks from the field for holidays, when changing hospitals and to reappraise fieldwork. The fieldwork was spread over a long period rather than being intensive and of short duration. This enabled participants to get used to my presence as I became a casual member of the scene and also helped me to get a clearer understanding of the setting. In the study, interviews took place with: thirty four student nurses with representation of all grades, four staff nurses, four ward sisters (including two deputy sisters) and six tutors (1). The use of participant observation meant that numerous informal discussions also took place with all of these grades both individually and in groups (2). Goffman (1968, p.7) says:

> "It .... is my belief that any group of persons - prisoners, primitives, pilots, or patients - develop a life of their own that becomes meaningful, reasonable, and normal once you get to it, and that a good way to learn about any of these worlds is to submit oneself in the company of the members to the daily round of petty contingencies to which they are subject."

To this end, participant observation was used to get a further understanding of students' experiences and to seek clarification of ideas generated in interviews. As with Olesen and Whittaker's (1968) study the rationale was that the best way to understand the process was to become part of it. Observation took place in the schools of nursing, classrooms, and on four wards. The four wards were located in three study hospitals (3).

Selection and Sampling

A pilot study was conducted in one hospital over a two month period (4). The main study was conducted in two hospitals over a thirteen month

period. Hospitals were not selected randomly but were selected on the basis of 'representativeness'. For example, one hospital is run by a religious order and is considered to be the main training hospital in the country, while the other two hospitals are run by non-religious bodies and have well established training schools. Within the hospitals, selection of wards was also non-random, the only criteria being that they should be general medical or general surgical wards. Trained staff were recruited for interview from these wards. Their selection was non-random, ward allocation being the only criterion for selection. Ward sisters were approached because they were the only ward sister on a ward and staff nurses because they were on duty at a particular time and day. Selection of tutors for interview was random as was selection of student nurses 'within sets'. As 'blocks' of students came and went from the school, I randomly selected students for interview (5). The study was cross-sectional, not longitudinal so there was no loss due to attrition. This study makes no claim to representativeness of student nurses' experiences in general (6). The settings studied are unique. However, I would suggest that the experiences may be universal as McIntosh (1977, pp.12-13) suggests in his study where: <the>

> "central aim was to provide a means of intensive investigation, an in-depth and processual account of awareness, information seeking and the management of communication in one particular locale. Nevertheless while obtained on one ward, many of the findings are universal in their application. Although the setting is unique the problems examined are not."

The findings of in-depth studies can be tested at a later date using a large scale survey where appropriate. In this respect, this study is considered a preliminary to a more generally representative study.

Negotiation of Access

The importance of discussing problems of access as well as interpretation in field research has been indicated by Cicourel (1964, p. 58). I suggest that negotiation of access to a study population must be

discussed in relation to the proposed methodology as some methods may find easier acceptance among study populations than others. I suggest that a quantitative methodology may have found easier acceptance once in the field but more sanctioning of questions etc. prior to entry. Whereas the qualitative methodology adopted in this study necessitated lengthy discussions and reassurances as to 'what I would be about' before entry to the field, and presented problems for those e.g. tutors who were to be the objects of such scrutiny (7). However, once in the field, the qualitative method in other respects gave me a 'freer rein' as a researcher, as, after initial access had been negotiated my methods and objectives could not be the subject of direct scrutiny. The potential for the researcher to exploit is much greater in qualitative research than in quantitative, as the researcher is in many ways subject to less control. Thus the researcher's own ethical code is most important.

My access to the study hospitals was through a number of personal contacts and introductions. Having a nursing background and being involved and showing an interest in nurse education and research helped me to gain access (8). In two of the hospitals, when access was requested, I initially had to meet the matrons and explain the purpose and methods of the study to them. I stated that what I wanted to do was to describe nurse training with a particular focus on the students' point of view. I explained that the methods I wished to use in the study were those of participant observation and unstructured interviewing. At this stage I also explained to matron, and subsequently to principal tutors and tutors, that, as well as interviewing and observing students, this would involve interviewing and observing other people, for example in the classroom and in the ward setting. What I made clear was that my focus would not be the tutor in the school, or the ward sister on the ward, but the student nurse. In this way I hoped to appear less threatening to trained staff who might

feel uneasy at my presence and raise objections. The interesting point is that access was gained directly through the matrons (except in one hospital, the hospital where I was already involved and had contact with the principal tutor, but I still did meet matron to explain the study). It seems that the matrons decided that I should have access and then the tutors and ward staff co-operated with this decision.

Access to classroom observation was problematic in both St. Robert's and St. George's. In St. George's, my initial request to observe tutors' classroom sessions was met with "we'll see about that later" by the principal tutor. Having missed this initial opportunity, partly because of my uncertainty with regard to access, it was some time later before I was able to negotiate classroom observation with two tutors. I overcame the problem in St. Robert's by insisting that the first stage in the research programme was to observe classroom sessions. Although initial access was granted by superordinates, for my own comfort, and that of those whom I was observing, I was constantly negotiating access throughout the fieldwork stage. This involved constant explanation regarding the research, and some self-disclosure. Olesen and Whittaker (1968, p.37) note:

> "To know us as persons eased the burdens imposed by us as researchers; our willingness to take excursions into our own life roles facilitated them doing likewise"

While Glaser and Strauss (1967, p.226) note:

> "The fieldworker who has observed closely in this social world has had, in a profound sense, to live there. He has been sufficiently immersed in this world to know it, but at the same time has retained enough detachment to think theoretically about what he has seen and lived through.....his display of understanding and sympathy for their mode of life permits sufficient trust in him so that he is not cut off from seeing important events, hearing important conversations, and perhaps seeing important documents. If that trust is not developed, his analysis suffers."

As Glaser and Strauss indicate, a feature of continual negotiation and maintenance of access is the necessity for the creation of an atmosphere of trust. In this study a basis for the development of trust can be seen

in my identity as a nurse and my ability to discuss nursing problems. Without the development of trust the fieldworker may find access difficult or even when in the field may find herself cut off from useful sources of information.

The Interviews

Unstructured interviews were conducted with forty eight respondents. Kidder (1981) states that the unstructured interview is best used when investigators are scouting a new area of research or when they want to find out what the basic issues are, how people see the topic, what language is used by respondents, and their level of understanding. She states that:

> "Not only does it permit the subjects definition of the the interviewing situation to receive full and detailed expression, but it should also list personal and social context of beliefs and feelings. This type of interview achieves its purpose to the extent that the subject's responses are spontaneous rather than forced..." (Kidder 1981, p.187)

This flexibility allowed new areas to be incorporated as they arose from previous interviews, observation and discussion. Glaser and Strauss (1967) stress the opportunity such flexible methods present for theory development, building and testing.

The Course of the Interviews

On first meeting respondents to arrange interviews and at the commencement of interviews I explained to the student nurses that their names had been selected at random and I encouraged them to ask questions. This seemed to be particularly important prior to interviewing as there was a certain apprehension regarding the tape recording of interviews. Interviews, on average, lasted two hours. Some took less time than this, notably, the interviews with the very junior P.T.S. nurses who had only been in the hospital for seven to eight weeks, whilst with the more senior nurses they lasted up to three hours; interviews were often terminated simply because respondents had to take their leave. I developed an interview guide in order to reduce anxiety and pressure on the interviewee

and to record areas covered in interview. Interviews were conducted in a variety of places ranging from a spare room in the school of nursing to the nurses' homes, ward sitting rooms or offices. All interviews with the students were conducted during off-duty hours, and with all others in the course of the on-duty period. All interviews were tape recorded and later transcribed to 'cope-chat' cards (I discuss analysis of data later in this chapter). My interview guide did not determine the course of the interview but was used to stimulate respondents when appropriate (9). The interview guide was designed to avoid long gaps or silences in interviews and to assist the less extroverted to present their views. It was concerned with eliciting information on images of nursing, on the school of nursing, on nursing examinations, on the allocation of ward work, on ward reports, hospital organization and family background and education. My interviews with student nurses began either as I explained, or by the student nurses asking questions about my nursing background and our talking in general about what I was trying to do. I continued by saying to nurses - "I am interested in how you feel about nursing and in knowing something about your experiences as students - what it is to be a student - and how you feel about that." If this did not start a conversation I followed it up by saying "tell me what stage of training you are at and how you felt about nursing when you first started". This would naturally get the student nurse talking about nursing and I might interject with another question if she did not expand on how she felt when she started, I would ask how she feels now and attempt to get her to talk about her experiences. The interview would then proceed in a very informal conversational style. Often it included the interviewee asking me questions, which, if I felt would not affect her responses, I answered. The interview guide was followed in varying order, but many of the topics in the guide were usually raised without prompting by respondents in the course of the conversation. A similar approach was adopted for interviews with trained staff.

Interviewing students did not present any problems. Outside of working hours they all turned up for interview, often with ideas about items they wished to discuss. At least four individual students turned up for interviews having organised group discussions in their flats the previous evening to decide what we should talk about and what items they should bring up in the interview. The staff nurses and sisters presented more difficulty. One deputy sister and one sister used the excuse of 'busyness' but at the same time reassured me that they would be interviewed. The deputy sister was interviewed on the second attempt but the ward sister took five subsequent attempts. Amongst the tutors with whom I had spent more time and established good relationships I had no difficulties with interviews.

Observation

The flexibility of the observational role and the four different aspects of this role, ranging from participant observer to observation, for example through a two-way mirror, have been discussed by Gold (1958) (10). My own observational role was something of the observer cum participant, the observer first, the participant second - and also participant to the extent that it is impossible to be observing the social situation, i.e. to be physically present, without affecting the situation to some degree and being a participant to some extent. Vidich (1970, p.164) states:

> "Participant observation enables the research worker to secure his data within the mediums, symbols, and experiential worlds which have meaning to his respondents. Its intent is to prevent imposing alien meanings upon the actions of the subjects."

Observation took place on wards and in the schools of nursing in the three hospitals. Methods of participant observation on wards varied from hospital to hospital because of the layout of wards (11). In St. Paul's and St. Robert's, with their nightingale-type wards, a combination of observational methods was used i.e. observation from a vantage point and observation through accompanying students in the course of their work. In

St. George's, where observation of the whole ward from a vantage point was impossible, observation was by accompanying and 'working with' student nurses (12) (I found that I rarely went with two students as all students appeared to work on their own for most of the time). During the course of my observation, except when in the classroom, I wore a white coat. This was as necessary for the discreet notebook and pen, as it was for bestowing a seemingly legitimate hospital role on me. In this way it precluded some questioning as to my presence. Since students in two of the hospitals were used to clinical teachers being around the wards, commencing my study in the school of nursing facilitated my acceptance on the wards. Also, when I went to the wards I was able to reassure people that I had already been studying the school of nursing. This was fortuitous as it gave the ward staff an umbrella under which to see me (13). This categorization of me as in some way associated with the school and tutors was helpful in the early stages as I sought initial acceptance. It also coincided with the aim of my study as it gave me a pretext for spending much of my time with student nurses. In the course of observation, I soon learned to disassociate myself from the school of nursing as I found students almost expecting me to check their procedures. On the wards, whenever I felt myself out on a limb or on the edge of events, I approached a student and asked if I could join her. On such occasions, the junior nurses (those in their first six months of training), would often say in an apologetic manner, "I don't know what I should be doing" and I would respond saying "that doesn't matter, I'll just stay if you don't mind." Because I chose to go up to students in this way, I did miss the interaction of some of the rest of the ward but, since the main focus of my work was to describe the experiences of student nurses, I felt that this approach was justified.

Observational Periods

Observational periods in the wards were for a maximum of one hour at a

time followed by brief sojourns to write up notes of students' work and activities including their patient and staff contacts for the periods. The observation was unstructured in the sense that I attempted to record what students did, where they spent their time and with whom they had contact for the period (students, staff nurse, sisters, patients and doctors). I had a small notebook in which I jotted down key words, as some events occurred, and then I removed myself from the students, sometimes to the treatment room, the sluice, etc., to write up. Observation was not recorded in situ, so the obtrusiveness of the method was reduced. I decided against on-the-spot note-taking in order to avoid disruption and to avoid causing anxiety. Altschul (1972) had noted in her pilot study that on-the-spot note-taking did cause anxiety but she still opted for this method of recording information in her study. In my pilot study I found it practically impossible to be with people and make notes in their presence. As I was trying to gain people's confidence and to act in an apparently casual, non judgemental way, I felt that on-the-spot note-taking had to be kept to an absolute minimum. This did not present a problem in the classroom. When in the classroom I simply sat down and listened to the lecture and jotted notes down as though I was taking notes of what the lecturer was saying, etc. In other words, I assumed the outward role of the student.

Observer Effects

Since the Hawthorne Electric Co. studies (Roethlisberger and Dickson, 1939), researchers have been aware of the dangers of creating a 'Hawthorne effect' in the course of their work. Most especially, it can present as a problem in the course of participant observation, where subjects are exposed to the first hand scrutiny of the researcher. My own study proved no exception and there were occasions when I was aware that my presence as a researcher could be affecting the events I was observing.

In one hospital, St. Paul's, I felt that my presence initially affected what was happening at one of the report sessions. The first day I sat in on report, in this instance given by a staff nurse, although she had nothing written (other than patients' names) in the book from which she was giving the report, the session lasted over an hour. It started at 1.40 p.m. and not finish until 2.45 p.m. This occurred despite the fact that the morning shift was due off at 2.15 p.m. and I felt that the length of this report was related to my presence. On that occasion explanations were given and time was spent discussing case histories and explaining what had happened to patients since their admission. On subsequent occasions the reports were given in about half an hour. On these latter occasions, the students' questioning was often stopped by the staff nurse saying "we must get on, the girls are waiting to get off". This 'observer effect' at report sessions did not occur in St. George's because there, student nurses wrote and delivered the report. They were delivering the report in the presence of sister and hence did not feel constrained to alter behaviour, as sister made few introductions. So it was often assumed I was a new 'nurse' and there to learn. Initially in St. Robert's where the senior on duty, i.e. staff nurse or sister, gave report, I felt that at first report sessions patients' diagnoses etc. were explored at greater length but this soon 'settled down' as it became accepted that I was present on such occasions.

In one school of nursing (St. Robert's), observer effect manifested itself in another way. Students had been told that I was coming to observe their behaviour in class and that they should 'wake up and participate'. This became apparent in my initial meeting with this group of students and in the individual interviews which followed it. However, in the course of observation in that school, I was told by subjects on a number of occasions that I was unobtrusive and that they had forgotten I was there to observe.

In the classroom, students afterwards told me that at times they did not even know that I was sitting in at the back of the class because I had come in just as class had started and they had not been aware of that happening. So, in many cases, I felt that I did not affect what was happening in the classroom from the students' point of view. Tutors were always conscious of my presence and it was only with outside lecturers that I could become 'one of the students'.

Observer effect manifested itself on another occasion on a ward in relation to patients who had been in for two and a half weeks for surgery and were now post-operative. These patients had enquired earlier as to who I was and learned that I was doing research. The patients took the opportunity, I feel partly because of my presence, to complain about the care that they were receiving. In this case it was the lack of communication with the doctor and the nurses' refusal to answer their queries.

Two factors contributed to overcoming the problem of observer effect on nurses: One was the presentation of myself as a nurse, as one who understood nursing issues (Cormac <1976> found that this also contributed to his acceptance); the other was the carrying out of the study over a protracted period and the development of good field relationships with subjects as the study evolved. The occasions when I became aware of observer effect and made allowances for it were at the beginning of the study; when observing new groups of students in the school of nursing; and when commencing the study of a new hospital, ward or school. The more time spent in these areas and the more taken-for-granted my presence became, the more I felt that participants accepted my presence. This indicates the importance of carrying out participant observation over an extended period rather than in short, sharp bursts. Kidder (1981, p.110) has noted:

> "the more time a participant observer spends with the public he or she studies, the less influence the observer exerts as researcher because although the research subjects may wish to

appear a particular way in the researcher's eyes, they cannot act in unnatural ways if the observer stays with them very long. The more the participant observer is immersed in the research setting, therefore, the less likely the research subjects are to distort the research."

TRIANGULATION OF METHOD

Triangulation of method was an important feature of this study (see ch. 2) as data from a variety of sources contributed to the level of understanding reached. Apart from the main methods of interviewing and observation on wards and in the school, other supportive material was obtained, for example, in the course of discussions with tutors and students at coffee sessions etc., from classroom timetables, ward duty rosters, work allocation books and dressings books. There was thus a triangulation of methods. My nursing role permitted me to observe nurse-patient interaction directly and left me free to move around the ward. I frequently left the student I was with to see what other students were doing and how the trained staff and the students were dispersed and occupied. Fox (1966) indicated that observation is the best method for describing behaviour. If I had confined myself to interviewing and other sources, e.g. the ward work allocation book, I would have had a very clear-cut impression of nursing routine and work, which would not have adequately reflected reality.

Because of this triangulation of method, I was sometimes in the position of being faced with discrepancies between observed and reported fact. I was, thus, in a position to present subjects with discrepancies. Replies to my probing were often of the nature that the reported fact was what should be done, but agreement that it was not the case in practice. Also, students in interviews described the course of their working day, but what did not become obvious until observation was the fragmentation of the 'jobs' that they performed. During observation, I found that students frequently left me as they went off to collect a forgotten piece of

equipment or simply would walk away, go from behind the screens and say "I will be back in a minute". I found initially when I stayed that students did not return for long periods, so I developed the habit of making sure that if a student left the bedside, I left with her. By not going with her, I was missing what is seemingly at the very centre of nursing work, that is, the fragmentation of work (see p.244). Students, I observed, were rarely left to get on with just one job. They frequently had to move from job to job; half finishing this or half finishing that, maybe waiting for a dressing trolley to be free. So I found nurses chopping and changing between jobs, or just waiting around while they waited to continue the dressing round. They were also frequently interrupted and asked to do other jobs after work had been allocated for the shift.

Becker and Geer (1957) note that very often participant observation, coupled with interviewing, can affect distortion arising from the interview situation itself. They point to the example of interviewing medical students, where they found that medical students frequently felt that they were being 'picked on', that they were being told off on absolutely every conceiveable occasion. Becker said that he had to accept this until he was in a position of actually observing a resident correcting a student. He noted that the resident simply suggested a technique that might have prevented a minor relapse in a patient assigned to one of the students. Shortly afterwards, Becker observed this student reporting to several other students that the resident had chewed him out for failing to use this technique. Becker then said that "he didn't really chew you out, I thought he was pretty decent" on which occasion another student said "any chance they get they chew us out" and Becker states that if he hadn't been in a position to observe this interaction between the resident and the student he would have had a distorted view. I would not have had the same confidence in findings if I had only interviewed students, and interviews

with tutors and trained staff assisted greatly in understanding students' experiences of training.

In many ways, the role of researcher that I eventually assumed was really unplanned. I had anticipated that I would undertake unstructured interviewing and participant observation on the wards but what I had not envisaged was the amount of informal information which I collected as a result of the relationships built up with the various subjects. Because this was collected in such an informal way there was not any way that I could have formalized the collection of that type of information in advance. Such information sources must be one of the bonuses of participant observation because they arise as a result of the relationship built up between the researcher and the researched. Olesen and Whittaker (1968 p.55) note this when they state:

> "By way of conclusion, we emphasize that the researchers as persons constitute a significant element in the full understanding of this study. We, the researchers, experienced, created, and constituted a world in common with the people studied, and because of this, cannot be ignored as beings utterly removed. Rather we were vehicles, albeit aware and hopefully insightful, through which data were shaped and revealed. Further, we were not initially knowledgeable about how intersubjectivity with the actors would be constituted, just how the data would be revealed, but rather we, like the actors, grew into this awareness in the process of becoming."

The description of what transpired on the ward and in the school was required because of the processes under investigation. While documentation of what occurred on the ward could be obtained by means of careful and comprehensive observation, explanation of the observed processes could only be achieved through analysis of comparative observations. Since some data could not be obtained through observation, interviews were also undertaken, the two methods being complementary and equally essential. For example, in interviews, I was able to draw on my observational experience and on group discussions in bringing up topics in relation to interaction with ward sisters or doctors, and ward work generally. I was also, of course, drawing on my own knowledge and experience of nursing. In participant observation

Rosenthal et al. (1980, p. 143) says:

> "reliability is invested less in the repeatibility of observation than in an on-going observational process in which the observers are led to question systematically the typicality of an observation, the social conditions under which the type of observed behaviour occurs, and the interpretation given the observed behaviour by those observed. In this way, the very meaning and definition of an observed event changes, making any rigorous application of inter-coder reliability irrelevant. In the last analysis, the reader is asked to trust the observers and to judge the sensibility of the patterns described as patterns, and the fit between the interpretations offered by the authors and those of the observed which are selected by the authors and presented in the text verbatim as field observations."

In general, the research process was one of working back and forth between observational, interview data and informal discussions while reflecting on my experience of the nursing world. Data were treated as an increasing store of information which was reconsidered constantly, it was not just collected as data to be analysed at a later date. At the end of the data collection period I had eight notebooks with observational records; over one hundred hours of interview material, a number of diaries kept by student and staff nurses of their days' work activities; and other records as they were available e.g. copies of timetables, material relating to the school of nursing and to the ward situation, work rotas, off-duty lists, and a wealth of informal information.

RECORDING AND ANALYSIS

As indicated, all interviews were tape recorded and records made of participant observation at regular intervals while in the field. All material collected was transcribed to 'cope-chat' analysis cards for

perusal as collected. All data were examined for themes, thus allowing the actual fieldwork, in presenting the students' accounts and experiences, to generate the theory. This was complimented by my own knowledge and experience of the hospital situation and by the perspective outlined in chapter 2. Cicourel says that the actor experiences the world within his reach as part of his unique biographical situation. Because of this, the actor approaches the role taking situation in ignorance or with background knowledge of customs. Schutz (cited in Cicourel 1964, p. 224) says that no findings stand independent of the method of production, and Cicourel (1964) states that if the opposite is assumed then it:

> "..tends to make social research something of a closed enterprise rather than an open search for knowledge relative to a given era." (Ibid. p. 224).

Glaser and Strauss (1967, p. 227) support this transferral of the researcher's insight to the research situation. They suggest:

> "What the field worker does is to make this normal strategy of reflective persons into a successful research strategy...of course, a trained, competent researcher is much more systematic in generating his ideas than is the ordinary visitor; if he is a superior researcher, his knowledge is likely to be generalized and systematically integrated into a theory."

As themes emerged from interviews and observation, index cards were used for recording items of interest as they appeared. As Glaser and Strauss (1967) suggest may occur I found my emphasis changing throughout the study, and my methodology changed. I had intended doing follow-up interviews with the students but found instead that clarification and further information could be more readily obtained by having informal conversations , in the course of ward ward, and at coffee break etc., with nurses on the wards where I was observing.

The Constant Comparative Method

The constant comparative method was the mode of analysis in this study. On the constant comparative method, Glaser and Strauss (1967, p. 47) state that the researcher compares incident for incident to establish

categories and, on the basis of the emerging analysis, goes on to collect further data:

> "The emerging theory points to the next steps - the sociologist does not know them until he is guided by emerging gaps in his theory and by research questions suggested by previous answers."

I perused transcripts not just at the end of the fieldwork stage but between interviews and observation periods, not only for key words but for instances of events (that is, reading transcripts not simply to extract key words but for the meaning of events). In relation to this task, Glaser and Strauss (1967, p. 251) see the researcher

> "as a highly sensitised and systematic agent...the researcher has insights, and he can make the most of them...through comparative analysis. The root sources of all significant theorising is the sensitive insights of the observer himself."

They suggest that, in any kind of research, no substitute exists for the imaginative insight of the researcher. What is most difficult to explicate in this account of analysis, but which must be borne in mind, is the way in which my own experiences of nursing and the wealth of informal knowledge acquired in the course of the study, contributed to this interpretation.

Throughout the course of the data collection stage, I fed information I had, and the new knowledge gained back into the study. Topics to pursue further presented in the course of fieldwork and were followed up. There was in that sense a 'feeding in' and familiarity with the data. When the fieldwork stage had been completed, analysis of the accumulation of data took place. At that final stage, I again went through each record of interviewing and observation and made a list of categories of events and key words. At this stage, I had around three hundred categories of events for further analysis. I had sixteen (8 inch by 5 inch) index cards full of closely written, usually single, words; these I studied and transferred to cards, one card (3 inch by 5 inch) per category of event. Here I found some overlapping of categories and key words and hence was able to reduce

the overall number. When original categories had different headings but the same meaning (for example, subservience/lack of assertion), I wrote these on the one card under a general heading i.e. assertiveness. Likewise, under the general heading of status appeared items such as juniors, 'way down'/undervalued, deference, division of labour, new bands/badges/belts, delegation of lower status tasks etc. Where appropriate I cross-referenced to another card, many of the above items also appeared in the hierarchy category. Some categories, at this preliminary stage, necessitated two or three cards. It was apparent that, although over 300 events/words were categorised thus, there was much cross-referencing and overlap and hence the number could be reduced by broadening categories. In this way I developed my understanding of the meaning of the data, as themes that were important in nurse training became evident. Having got this far, I continued to study cards for further cross-referencing (having put all category headings, now less than 100, on one sheet of A4 paper in alphabetical order). The next step was to decide which categories suggested emerging concepts and I started this project by exploring those categories which necessitated two or three cards. Taking these, I began with status (14) and proceeded to re-read participant observation records and tape transcripts. As categories appeared on the 'cope-chat' cards, I coded them by hand punching. Where appropriate, these cards permitted cross-referencing. This enabled me to study all items under each category as one and to compare them with all items under other categories, for example, I was able to compare the 'status' category with the 'hierarchy' category and see if such categories should be brought together under a single category. Gradually, in this way, a picture of the training experience began to emerge.

PRESENTATION OF DATA

Although status appeared to be the single most important category it made sense to present this account of nurse training in a chronological way bearing in mind the emergent themes. The decision to present in this way was based on a desire to accurately reflect training as experienced by students. It is an alternative mode of presentation to that adopted by Melia (1981), as it places students accounts in the context of the hospital training school (15). It attempts to 'tell-a-story' in a 'chronological' way making for easy-to-follow plausible accounts for the reader. Its effect on the ordering of data is to represent a typical series of events in the life of the students studied. It is a construction of an ideal type of student nurse training in the Republic of Ireland. This ideal type may need some modification (perhaps following larger scale survey type research). Fallding (1971) points out that ideal type building is a beginning not an end. On the ideal type he cites Weber (1949, p.104) as follows:

> "it serves as a harbor until one has learned to navigate safely in the vast sea of empirical fact." (cited in Fallding, 1971, p.504)

and Fallding (1971, p.505) states:

> "If the same blemishes begin to occur quite regularly on the pure type we will begin to suspect that is the shape of reality".

Once accepted, the ideal type can be adopted as a hypothesis and discarded as an ideal type.

CONCLUSION

The study, whilst being in the verstehen tradition and the acculturation perspective of many previous studies of occupational socialization (Olesen and Whittaker, 1968; Becker et al., 1961; Dingwall, 1974A; Melia 1981), attempts to encompass more than the most recent of these (Melia 1981), so as to give a more complete understanding of the life

of student nurses in the school of nursing and on the wards. Chapter 2 highlighted some existing approaches to the study of training experiences and showed how they informed the study; chapter 3 indicated the way in which this perspective became translated into a research methodology and highlighted some of my experiences as a researcher. As discussed (pp. 63,65), the theoretical perspective adopted gave rise to a number of guiding principles and interrelated research questions. These principles and questions constructed the fieldwork as they represented the need to move on from the work of Melia and to a lesser extent from that of Dingwall (1974A) to take account of wider aspects of training. In constructing this account of training, theoretical concerns also ultimately gave rise to the imposition of a framework for reporting. In presenting any research report a gloss of reporting is imposed, although ethnographic accounts, in presenting a 'natural history' or even adopting respondents' terminology for concepts, attempt to overcome this problem. A gloss of reporting may be identified in all the studies discussed. Dingwall (1974A), presents a 'natural history' account while Melia uses respondents' terminology to present emergent themes. Whilst this study did identify themes and these were used initially to make sense of the data, data are rearranged to present a chronological account of training, as an overall theme is explicated throughout and is developed in chapter 8. As interview data are used in the main to 'tell the story' it is a more personalized account of training than Dingwall's (1974A), being more similar to Melia's (1981) in this respect. At the same time the study presents a much broader account than Melia's (1981), as the story is located within the context of the hospital training school.

A framework for reporting has been imposed in constructing this account of nurse training. I suggest that it is justified as it highlights students' experiences of training and places them in context. Readers may

form their own judgement as, without this being a limiting factor , the data 'tells the story'. This story begins in chapter 4, where the student nurse commences her transformation, as she seeks out, or has thrust upon her, the requirements of the hospital training school.

FOOTNOTES

1. These figures include the sample for the pilot study. Profiles of students and all other respondents are included in appendices 1VA 1VB respectively.

2. Apart from this sample, I found that while working in nursing education I was developing my understanding and amassing information from a number of sources outside the study hospitals.

3. Three were surgical wards (one in the pilot study), and one was a medical ward. One surgical ward was mixed male and female and the other two surgical wards were male and female respectively (see appendix 111B for a further description of wards).

4. A pilot study was conducted in one hospital (St. Pauls), for the purpose of testing the unstructured interviewing method and clarifying my participant observer role. Some differences existed in relation to selection and observation of students in the pilot study. 1) Given the background information to which I had access as a member of staff in the school of nursing, I relied on students' accounts of classroom interaction and did not support those interview data with observation. 2) Selection of students for inclusion in the pilot study was made only on the basis of ward allocation. Data presented throughout chapters 4-7 includes data collected in the course of the pilot study. The pilot study samples are readily identifiable by referring to the student profiles in appendix 1VA.

5. With the 'block' system of training, students return full time to the school of nursing every 4-9 months for theoretical input for periods of 3-5 weeks.

6. Appendix 111A includes a description of the hospital training schools studied.

7. The fact that those who first granted access were not themselves to be objects of such personal scrutiny made this less problematic than it might have been.

8. My negotiation of access to do research and most especially to use participatant observation as a method of study, both in wards and

schools of nursing, was very much related to my nursing background, as I was identified as an appropriate person to have access to the nursing world.

9. A more detailed account of the interviews incorporating the interview guide is included in appendix 111D.

10 Gold's (1958) different roles in observation

1) Complete participant;
2) Participant observer role;
3) Observer as participant; and
4) Complete observer.

11. Descriptions of wards in the three hospitals are included in appendix 111B.

12. I did not take any responsibility for ward work or allow work to be allocated to a student because I was available to 'work with her'. Rather I moved around the wards, sometimes observing and sometimes 'going with' and perhaps assisting a student if she was already working alone.

13. It was also often the way in which student nurses introduced me or explained my presence to patients.

14 Status appeared most often and in chapter 8, I develop the concept of 'pipeline status' to reflect this experience.

15. In the accounts which follow data are drawn mainly from interviews. Where appropriate data from other sources (i.e. participant observation) are used to support interpretation. The experience of being a participant observer in the three hospitals, and my own experiences as a nurse are implicit in my understanding and interpretation of the data.

CHAPTER 4

'GOING TO BE A NURSE'

NEGOTIATION OF ENTRY TO GENERAL NURSE TRAINING

"The simplest sociological view of the individual and his self is that he is to himself what his place in an organization defines him to be".
(Goffman 1968, p. 28)

This chapter deals with the students' perceptions of the status of nursing; and their negotiation of, access to and initial contact with the hospital training school. It is concerned with how as the student nurse enters nursing she sees herself and her own role in the provision of health care. It attempts to let the data tell the story through presentation of respondents' images of the status of nursing and their experiences prior to, or soon after entry to nurse training. In the discussion I confine myself to notions of what it means to be a nurse and how this is presented to potential recruits and to new initiates. This represents in many respects the 'components' of the professional role and what it means to 'become a nurse'.

DECIDING ON NURSING AS A CAREER

In Ireland, there is no shortage of recruits for nursing, and hospitals can 'pick and choose' entrants who are usually of a high standard (1). Young women do not present for nurse training out of a vacuum: they all come into nursing with views, attitudes and impressions somewhat formed (2). Hanrahan (1968) reported in her study that nurses seemed to make

their career decisions at an early age and were probably influenced in this by family and friends. She found that a high proportion of respondents had relatives, who were, or had been involved in nursing or medicine. Davis' (1969) work in the United States found occupational role models higher among nursing than social work students. In this study, the greater proportion of students had parents or relatives who were in nursing or medicine. Simpson (1979, p. 69) found that the values nurses expect to realise from nursing "are ones associated with the traditional role of women" and that their parents tended to endorse traditional values for both sons and daughters; the endorsements being greater for daughters than sons.

From students' accounts, it is apparent that nursing for them is congruent with prevailing societal definitions of womanhood. Ruth Sweeney describes how she arrived at the decision to do nursing:

> "Its always been on my mind. I am a member of a large family so I remember going in to visit my mother in hospital having the last few babies and I liked the atmosphere in hospital - one of my sisters said to me she was going to be a nurse and I remember saying I would love to be a nurse too...I applied and then I decided that this was the best thing...you know nursing...to do for people and I would get more satisfaction out of it as well."

On what her father and mother thought of her doing nursing she stated: "They think it is a very noble profession. Its a nice career for a girl". She states that at school:

> "We were geared towards nursing really...nursing or teaching but they didn't really work towards university...they didn't really aim very high..."

Educationally, this student had university entry standard qualifications and had been told by her careers guidance teacher that she was university material. She remembers:

> "I was very confused in the last year especially, I didn't know what I wanted to do really and she narrowed it down to teaching or nursing and then I made the decision myself."

On what her parents felt regarding her choice of nursing, Eva Lane said:

> "They were delighted...my brother always said to me, he's in university, he said he would never advise a girl, it was just

being daft, a waste of six years or so."

The implication evidently was that time at university is wasted for a woman but three years hospital-based training is not. Suitable young women may find school programmes direct them to teaching or nursing. This is particularly the case in Ireland where the choices for middle-class, educated young women traditionally tend to revolve around either teaching or nursing (3). School programmes may even focus on such choices, and prepare pupils for this particular slot in the labour market.

IMAGES OF NURSING

Aspiring recruits may appreciate that nursing work may not be accorded high status in the 'professional market'. The following accounts give some idea of students' perceptions (based on their experiences), of the views of society regarding nursing. Ruth Sweeney who left a university arts programme after six months because she had 'got a place' in nursing, notes:

> "I met someone when I was in Queens and I said I was leaving to do nursing and he said, 'to do what?' and I said 'nursing'...he said... 'your're mad - you have got all these brains and you shouldn't waste time nursing'."

Eva Lane who had completed six months of a commerce degree programme states:

> "Everybody told me that it was going to be very hard and do you know what your're letting yourself in for and you spent most of your time doing overtime and all this kind of rubbish..."

Self-sacrifice is also anticipated. Maria Fox had her impressions of the status of nursing formed before she started training:

> "I was working in a hospital and I was trying to decide and thought I wouldn't do nursing...everyone shouts at you. You are always to blame, you are always the underdog. I would much prefer to do medicine I thought. I was doing my Leaving Certificate and anyway I wouldn't get the points for it and thought about nursing again...I think I prefer nursing to medicine because I think you are more in contact with your patients but its not really that...it is that patients are afraid

> of doctors, they hold them in awe. Even student doctors that you know, know very little, but because they are wearing a white coat patients are afraid to talk to them.

This student had already completed one year of a social science degree. On what she thought of P.T.S. and nursing Ruth Sweeney stated:

> "People run down nursing - run down the study aspect of it anyway and quite frankly I didn't think there would be as much study to the job. It's not really difficult, it just there is so much study crammed in to a few weeks and you have to study for say three or four hours a night and if you don't then you have that much work left over for the next night and then at the end of the week it piles up."

She had not anticipated the amount of study that might be involved:

> "I think it is a general attitude. Also I think, my sister is doing medicine and she is very sarcastic...she thinks there is nothing like medicine and so nursing...there is nothing to it sort of...and there we are having to swot away. At the weekend I was telling my mother about my exams at the end of the week and that I wouldn't be coming home again because I wanted to study and she <my sister> was roaring laughing because she has her finals shortly in June and me talking about P.T.S. exams."

Ursula Dwyer, whose father was a medical practitioner reports:

> "Before I came in here, dad was trying to discourage me as much as he could...and he was saying that you have to do all these things like giving bedpans and things like that...and I remember thinking at the time doing bedpans and washing people and I couldn't picture it and I gave up the idea for a while and then I went back to it again. Even still, actually a woman, my friend's mother, said to me the other day 'how can you become a nurse and be doing all those grotty jobs and everything?'. They think you do nothing else."

She identifies 'dirty work' and its low status in nursing and society and her last comment suggests she already aspires to moving away from low status work, her esteem comes from those other aspects of her work. Her concern is "they think you do nothing else".

Davidoff (1976) discusses the way in which 'dirty' (contaminating) work comes to be associated with low status and women's work. I suggest that low status for nurses is inherent in the nature of the work they do, as, whatever status they achieve is derived 'second hand' from the 'reflected glory' of working 'alongside' high status medicine (Treacy, 1979). Two of the students I interviewed were completing post-basic

general registration, one having done psychiatry, the other having done paediatrics - all had come to do general, because it would assist promotion in their respective fields. Of all nursing, general nursing has the highest status and it would appear most sought after. General training is usually the first choice of applicants. Before starting nursing, students already have these images of the low status of various nursing specialities e.g. Eva Lane (and others) wanted originally to do children's nursing, but instead did general because she was advised it was 'better' to do general. This supports the notion that nursing's status is derived second hand from medicine, as that part of nursing most closely associated with medicine and the medical model is most sought after and accorded highest status. New recruits to nursing are aware of the position of nursing relative to medicine in society. Accounts indicate that they are also aware that doctors control but do not involve themselves in low-level tasks and appreciate their own relative lack of status. The status of the student nurse in the hospital training school is discussed later in this chapter (p. 110) and in chapter 7.

GETTING ACCEPTED FOR TRAINING

Student nurses coming for interview receive advice from those already in nursing as to organizational demands and expectations, as the following account suggests. Ursula Dwyer recalls:

> "Before I went into nursing you hear all these things like matrons are really terrible and that you have to be obedient come hell or high water you just have to. Oh, you'll be under their thumb and that sort of thing."

Ruth Sweeney reports that at interview:

> "They asked me what my parents were doing and if I knew of anybody else in George's or did I have any relatives who were nurses but I didn't...They really fired questions at me, I was convinced I hadn't got it. I was really depressed after it. They said my father 'is an accountant so why don't I do that?' I didn't want to so I was sure that they were more or less telling

me I hadn't got it. I was delighted to get it..."

In interviews students suggested that they found an emphasis on parental background and their immersion in a medical or nursing milieu. It would appear that pre-selection to nursing takes place by hospitals which can pick and choose from candidates with a high educational standard. All candidates are interviewed and emphasis is based on a real interest in nursing or experience of the nursing or medical world. Thus, questions are always asked regarding who else in the family is in nursing or medicine, or if a family has any association with the hospital? The assistant matron in one hospital suggests that such candidates may have a much better chance of staying the course. The message also came across to candidates quite clearly. Angela Connor who had no relatives in nursing complained that she felt that such people were discriminated against in selection - she had formed this opinion not just from her interviews in the study hospital but also in the interviews she attended elsewhere. The majority of students either had relatives who were nurses or doctors or like Angela had managed to get work as a nursing auxiliary before training. Candidates for training are aware that whatever their educational background, such 'experience' gives them 'the edge' over other candidates. It seems that hospital authorities do not take on young women unless they can demonstrate that they have some idea what to expect, they do not want problems arising and hence they try at interview to locate candidates' 'real' interest. It seems that hospitals may attempt to recruit people who are likely to accept prevailing definitions and conditions in nursing (4).

At interviews, students 'act out' hospital expectations and may be 'told the score'. Peter Finnegan a post-registration male nurse recounts the interview he had with the principal tutor prior to his acceptance (5). I suggest that the story told is significant. It implies the statement that 'nurses must be willing to serve':

"When I was being interviewed, she asked me, we were discussing

about people qualified from university, and she said, 'did I feel there were jobs for them?' and I said they should take something until they get their own job, and she agreed with me and said she found girls coming into her and they would be looking for temporary work, then she would put the question to them, 'how would it be if somebody messed over the floor there and you were asked to clean it up?' and she said that girls would turn round and tell her, 'I didn't spend three years at university to clean up other peoples' messes', so she says they deserve to be left unemployed..."

Deirdre Kane recalls:

"Some of the questions I remember from my interview and one of them was, 'who gets you up in the morning?' and I said 'I get up first and I call the family' and this seemed to go down very well and then they asked me a question on disobedience, and the need for discipline and I anwered them a pit-pat answer because I knew it was what they wanted and when I left that interview I just said to myself, 'I bet you I have got it'...it wasn't what I felt but I knew what they wanted - it was so silly."

Student nurses start nurse training highly motivated and receptive to the needs of the institution within which they hope to succeed. Even before training commences, they are reading the informal curriculum. It seems that new initiates come into nursing with some snippets of information about what might be expected of them; they come to interviews with an awareness of the appropriate 'front' to present in order to be considered for selection. The following lengthy account illustrates how 'vetting' takes place at interviews and how messages are transmitted. Maria Fox already on a university course states:

"Well, all I remember was the faces of the three in front of me and I was coming in on my best behaviour and I had already been accepted to go to college and I had been told 'don't tell them because if they know you have got another place they won't take you'. They were looking at my results and they were looking at my matric and they were saying - 'why aren't you going to college?' and I said, 'there is nothing I am interested in doing' and they said, 'very funny, really' and I said again, 'I don't really want to do anything there'. That was two years ago but this year the daughter of one of my parent's friends went for an interview here and the first question she was asked, 'what makes you think that you should get a place here in front of girls who have six or seven honours?' What happened was I was supposed to start nursing in March but I had started in college before I got the 'Yes, we would like you to join and start nursing in March' and I was thinking I am not really enjoying college but I would like to stay here until September and get my first year because the fees were paid, so I thought I would go down and see if I could change. So I came down and I was coming straight from college, I was in my college clothes, my hair was wild...I never thought of it and my nails

were really long and painted purple and I had an interview with matron and I explained my position and asked her, 'would it be possible for me to change from the March list to the September list?' and she was so taken back. She kept saying, 'no, I don't think so' and all this and I was saying 'if it would jeopardise my chance at all well...' and she said, 'I could move you onto the September list but I couldn't say I would give you a place' and I was saying, 'oh! if that will happen then of course I will give college up but it just seems to be such a waste. She asked what did my parents think and want you to do and I was saying 'they would like me to finish the year but they would like me to do whatever I would like to do but they really wanted me to stay in college rather than do nursing'. But she just h'mmed and hawed all the time and then the 'phone rang and she sent me outside the door and it seemed like hours and hours but it was only ten minutes and then she brought be back in again and she said, 'you know if you came at your interview dressed like that you would never have got it' and there I was... and then she said, 'alright, I will let you change'"

But as Maria says "that wasn't really the end of the story"; she explains:

"In one of my papers I didn't get honours and I wanted to repeat the honour in that one so that I could do an honours degree if I wanted to, but it meant my repeats were on the first day I was to start nursing! So I said 'I will go and do nursing' and my mother said, 'you will not, you will go and repeat your exams, I'll go down and ask matron and everything will be fine'. So mum went down and matron...said, 'Oh, I thought your daughter was dropping out' and mum explained the situation and matron wasn't really very helpful at all and she said, she didn't really think so but she would have to ask the tutors and she couldn't see if this was possible but she would let us know. Mum came home and told me and I thought I'm going to be in awful trouble. Then I was talking to friends who were nurses and I told them and they were saying, 'you're mad and crazy - you're not going to get in - they will kick you out - you won't make it'. I didn't know what to do and I went home to my mum and she was really set for me to do my repeat and get my honour and have something so I said to her 'I can't repeat this exam - they won't take me and they won't give it to me'. I was saying what other nurses had said and how much of a black mark it would be, which it was really when I think of it - a very big handicap - thanks be to God that I got all my exams!"

This student knew well what was expected of her before training began - basically she knew to seek nothing for herself and to exhibit a selflessness to the extent of not pursuing her university education. Students appreciate their good luck or good fortune in getting in to train as nurses. Maria Fox contrasts attitudes in nursing and in college:

M.F. "...they were really good in college and they were saying 'of course we will have you back - you know we mightn't be able to give you a year off but just apply officially and if I am still head of the faculty - of course I will have you back - no problem' and I know that would not have been the attitude in nursing. You can't say, 'can I come in two years time please?' -

you can't - you have to say, 'thank you, thank you for taking me'.

M.T. Where did you learn that?

M.F. ...they used even say to us in our first year of our so-called guidance talks - out of hundreds we picked you - not aren't you lucky - but there are hundreds to fill your places!"

It was made clear to this student that she had to make a choice between university and nursing. She felt that it was important that she should show a single minded interest in and commitment to nursing, and knew that she had to demonstrate 'her willingness to serve'.

Hospital training schools try to recruit carefully; they are conscious that in selecting they are choosing the nursing profession of the future. Two of the three hospitals gave students a test before interview (regardless of their educational attainment) to assess their suitability for nursing. Ruth Sweeney explains:

"We had to do a test just beforehand. There were very basic questions. I think my little brother could have answered them and two essays to do."

Despite being able to pick and choose from a variety of well-qualified applicants, a central admission qualifying test was introduced briefly for those who fail to fill normal educational requirements (6). Some trained staff recognise this pre-selection to nursing. Rita Fitzgerald, a tutor, notes: "Whenever we saw a job advertised...we'd say 'they forgot, they left out conforming women to apply." As indicated in the preceding accounts students had to demonstrate that they were the right sort of 'responsible' people who would 'fit-in' and have a 'real' interest in nursing, if they were to get a place in a training school. Nursing selection procedures reinforce these attitudes as educationally less able candidates can get accepted by means of their interview, aptitude tests, and references. The profession emits a conflicting message, on the one hand high educational standards enhance the profession as a whole and give added status, on the other hand there should always be a place for the less academically

minded if they have the right personality and attitude.

The foregoing suggests that girls come into nursing with some pre-knowledge of what might be expected of them. They are aware they will have to do 'messy or dirty work' which is looked down on as contaminating by society at large; this must have a bearing on the student nurses' self image. Those who are selected seem to have come to interviews with an awareness of the right way to behave or appear etc. and with pit-pat answers on such subjects as obedience and discipline. All know they have to demonstrate 'commitment'. Whether this willingness to demonstrate commitment arises from self selection by candidates or careful selection by hospitals is not clear. However, the directives and demands for its demonstration are representative of the control and uncertainty which accompanies the career of the student nurse.

THE COMMENCEMENT OF TRAINING

If new initiates already have an image of nursing requirements in mind before they start, it is confirmed once they commence training. Should students have any misconceptions as to their role these are dealt with in P.T.S. which consists of six to nine weeks of teaching mainly in the classroom, but with occasional supervised trips to the wards. Once this has been completed nurses are assigned to wards where they form part of the ward staff and assume a certain amount of responsibility for basic nursing care (see ch. 7). The everyday world of the student nurse is far removed from that of other students. One of the student nurses in my study explained: "You've got to be on par on all levels" meaning that ward work and school work ability are not the only criteria of success in the hospital. Student nurses learn, first of all that nursing is quite unlike any other career they might have chosen, apart from the army or religious life. At least in the army, all are aware that it is an outward conformity

to the rule that is required whereas in religious life it is an internalization of the rule. If students enter nursing thinking it is 'a job like any other' and few do, they soon find out otherwise. The 'role' of nurse cannot be easily left behind once class ends or the shift finishes, not at least for the first six months - twelve months as rules vary with regard to compulsory living-in in the nurses' home and as they find their behaviour practically everywhere subject to scrutiny, remark and correction (7). The remainder of this chapter serves as an introduction to these facets of nurses' experience and it is explored further in chapter 5.

As soon as students arrive in hospitals to commence training they become aware of the fact that the life of a student nurse is unlike that of students in general. For a start, in two of the hospitals parents are expected to arrive on the first day and to sign forms taking responsibility for their daughters when they are off hospital premises at specific locations. What is emphasized again and again is that student nurses are not permitted adult freedom. In one hospital, a 'guidelines' pamphlet given to all new recruits makes the following statement regarding the nurses' home:

> "The nurses' home is a private residence. Students reside there for the first two years of training. Matron is in loco parentis, therefore conditions discussed and agreed upon with the student's guardian concerning nights out and other regulations must be adhered to. During third year a student may live out in the following circumstances:...with permission from matron..."

Control is evident as students learn from the beginning that they are not being treated as responsible adults. Once they become student nurses they must live-in, and the hospital assumes its role and acts in <u>loco-parentis.</u> Students feel initially that they are 'the babies; and totally dependent. Patricia O'Brien remembers:

> "I think it is the attitude we got...first when we came in I felt we were the babies...I thought it was like the first day in primary school...even though they told us the first day we came in O.K. you are adults but yet we are treated as if we have no mind of our own...do this at this time and that at that time."

In St. Robert's; Paula Jennings explains further:

> "We have the interview the day we start here and I would never want to go through it again - this was the day we started here. One of your parents had to come with you and you had your contract to sign and the head tutor was there. I was second in to the place and the girl before me went in with a smile on her face and she came out with a face on her! I knew this was really going to be tough."

While the 'guidelines' pamphlet in St. George's also states:

> "When sick a student should report to the assistant matron during the day. At other times, he/she should bleep for the nursing officer. Consultation with the doctor of his/her choice shall be arranged. A student who is taking tablets or medication must inform matron."

Students learn that no one sphere of life can now proceed without some degree of interference or as will be seen surveillance, and they are informed that action will be taken for any breach of rules.

Student nurses' dependence is increased for the first two months of training as they receive bed and board from the hospital but no salary while in P.T.S. This justifies further separation as students find they are singled out in the canteen. Patricia O'Brien says:

> "You hand in this little pink card and everyone was looking at you! I felt that was very degrading and we were sent down to the back of the canteen, we couldn't sit up with the nurses that were on the wards. The first evening we all went over for our tea...we had our tray and we even put all our stuff on the table and we had to go down to the back and eat off the tray."

The new student nurse learns that she can no longer be responsible for her own actions and experiences a process of role stripping. As they commence training students also experience what they describe as 'pressure' (see ch. 6), they are aware that they are 'under scrutiny' and 'on trial' as the following suggests. Paula Jennings speaks:

P.J. "You were under pressure - from the moment we started in P.T.S. - all we would hear about is - if we fail you are out - and the assessments we did in P.T.S. were all supposed towards our final marks...so from day one you were under this terrible pressure and then they give you continuous assessments and you are out. It was constant pressure and unfortunately the two sets ahead of us had done their prelims. and none of them failed and the same behind us...and you didn't want to break that tradition.

M.T. Do you know of anyone who was asked to leave because they didn't get their exams?

P.J. No, but I know someone from the year ahead of us and I know someone out of their set did...but two were threatened in our class...these two seemed to be under awful pressure from day one...they seemed to be getting into trouble for nothing."

Should a student feel that once acceptance is gained she may relax, she soon learns that as far as the hospital is concerned she has few laurels to rest upon. Paula Jennings gives an account of her meeting with matron on arrival to commence training:

> "...and then she went on about my Leaving Cert. and I thought I did grand...I got my honour in hons. English and two others <8>...I was delighted and then she said 'that is an average result - you will have to work very hard here'. I mean I was delighted with my Leaving...that was average! My parents couldn't believe it."

To this is added their 'worker' responsibilities. Students describe the emphasis on the responsibilities they are told they must shoulder as they arrive with their parents to commence training and take up compulsory residence in the nurses' home. Margaret Nally remembers:

> "...some of the girls came out crying when I was going in for my interview. They were telling us about the responsibility that you were going to have as regards never having been in a hospital before or in a hospital situation where you had any responsibility and they were telling us about how you have to be very responsible and we needn't think that we can take this lightly and we have to think about this very seriously. Really, I thought they should have let us in a little bit more gently...I don't know whether they did say it to everyone or not but I felt it...This was an individual interview and you went in with your parents and they talked to you and talked also about our contracts. We were told if we weren't suitable we could be thrown out at any stage and that patients' lives were the most important thing, and to remember that any slip now wasn't a small slip...It was 'heavy' from the simple fact that I didn't know what to expect anyhow, and to hear that even before I had even been on the wards or felt at home in the place was very disconcerting."

From interviews it is apparent that it is not an isolated incident. Sheila McCann says:

> "...we found it very off putting, a lot of us did, they said it to a 'good few' of the girls but we kind of forgot about it I think. When you realised that you weren't the only person that they said it to and that they probably were saying it for a reason in case you were taking it lightly in that you weren't

just coming in because it was the only job left...thats not why they wanted you but that you really wanted to do it..."

As hospital training schools strive to 'guide' the new recruit, initial contacts between student and matron or senior nursing staff are used as 'pace setting' encounters. In these encounters the scene is set for the students' future role in the hospital training school and students experience dependence and control as a result. But 'pace setting' encounters continue throughout training and students are constantly reminded of 'their place' and what is expected of them. (see p.189). Many students reported feeling frightened by such encounters. These contribute greatly to students' feelings of uncertainty and pressure; they also feel devalued and demeaned as they feel that they are 'radically demoted in the age-grading structure' (see p.190). Through these type of encounters student nurses learn their place in the existing order of things. Preliminary training school is the time when the imagery becomes reality and students start to look forward eagerly and as will be seen 'fearfully' (see ch. 7), to the time when they will no longer be 'at the bottom of the pile'.

TRANSFORMATION AND THE NEW RECRUIT

Goffman (1968, p. 28) discusses the effects of loss of personal identity equipment and explains:

> "At admission loss of identity equipment can prevent the individual from presenting his usual image of himself to others. After admission, the image he presents is affected in another way. Given the expressive idiom of a particular civil society, certain movements, postures and stances will convey lowly images of the individual and be avoided as demeaning. Any regulation, command or task that forces the individual to adopt these movements or postures may mortify his self." (Ibid. p.30)

Without a single lesson in class, students can experience what it is to be a nurse and I suggest that for them status is problematic. For example, an important part of the hospital training school's attempt at transformation

of the new recruit are the orders and directives with regard to the appearance and behaviour of new initiates.

Appearance

Not content to confine the dramaturgy to the nurse in uniform, hospitals also attempt to control appearance while in mufti. Fiona D'Arcy recalls the rules relating to their appearance while in the classroom:

> "We were told not to wear any jewellery except for your watch. You wouldn't just go in with elaborate jewellery on either because it would be spotted immediately and you would be told you should only wear your ring and watch or whatever...The hospital policy is that we are not allowed and you would be told. In 2nd year block we were stopped all the time but they haven't reprimanded us about what we should wear or what we shouldn't but now at this stage you wouldn't do it anyway. Nobody would ever walk into the classroom with elaborate ear-rings on, even in 3rd year one girl was wearing a blouse and this girl really looked well in it and they just told her to take it off her and to put a jumper over it because the back was out of her blouse. I think it is a really bad system. They even told us about it when we came into block this time."

Joan Burke reports:

> "One of the girls in class had gold ear-rings on one day and she was told to take them off, and she sort of said why, and the lecturer said because we all know what type of girl wears long dangly ear-rings."

Patricia O'Brien describes how uniform shoes had to be worn in the classroom even though in mufti:

> "We were told to wear the shoes we wear on the ward to get our feet used to them...I didn't think it would take 8 weeks to get used to any shoes...they were nearly worn out at that stage! I think that was very degrading."

Rules abound with regard to appearance. Even when in mufti not one of the hospitals allowed students to wear jeans in class and one did not allow trousers. Sheila McCann lists the rules with regard to dress when in the classroom:

> "...skirts, tights, shoes...no jeans...no leg-warmers or knitted tights, and you hair has to be up...I think it is ridiculous in fact...hair up."

If individuals normally wear jeans or do not wear tights in warm weather, then restrictions can seem like a personal attack upon the self - as their

normal standards of dress, or as will be seen behaviour, are no longer acceptable and are subject to criticism. Such 'rules' exist in hospitals as attempts are made to control both behaviour and appearance.

The Uniform

The uniform is given a kind of sacredness, as in the military. It is much more than an overall to reduce cross-infection. The uniform may not be worn incomplete and students must learn how to wear it. Olesen and Whittaker (1968) see the uniform as a transference of the idealized values expected of the nurse and I would suggest women in general. They state:

> "A standard bib and apron meet in a nondescript fashion at the proximity of the waist, concealing as well as possible bosom and hips; the nurse is not physically seductive"... (Ibid. pp.63-64).

Fromm (1977, p.15) in the U.S.A. notes the reactions she encountered when she ceased to wear her cap:

> "From my first day of coming in without one, I was continually questioned as to my reasons for having left it off - questions such as 'where is your pride'? Is it meant to mean that a cap preferably one with 'NURSE' imprinted on it is the source of nurses 'pride'."

It appears that in the Irish hospital structure the uniform is regarded as absolutely vital and few student nurses would be allowed to spend a day on duty without their cap, much less cease to wear it altogether.

Once in uniform the role of the nurse takes over, even though only in the hospital a short time the new recruit is treated and responded to as a nurse, she has become a nurse. For example, Davis and Olesen (1963, p.94) note:

> "To the extent that the student nurse is noticed at all by medical or dental students, the approach of those males is...fashioned...by their 'categorization"' of her as a nurse...<than> whatever might ordinarily attract a boy or girl. Even when such qualities are appreciated, it is usually against the backdrop of the prior and controlling imagery of 'the nurse', as one might, for example, find himself bemused by a worldly clergyman or spendthrift French peasant. The nurses hands are not sticky and hot; they are always cool and soothing. The nurses' walk is not heralded by the click of heels and the sway of hips, but by the soft rustle of her starched garb and effortless smooth glide. A nurse never laughs raucously or

> giggles uncontrollably; she smiles gently and sweetly. A nurse does not yodel or sing about her work, stand with her hands upon her hips or slouch against a wall; she is always silently and tirelessly in the swift movement of work...she is always dignified and impeccably clean...eminently reasonable and always ladylike."

Similar imagery is evident in accounts in this study. Student nurses are also told very clearly what is expected of them. Carmel Macken describes what she was told under the topic of etiquette as she commenced P.T.S.:

> "Generally controlling yourself, never going out without your veil on. I think your appearance more than anything else really. They barely mention the normal thing like disclosing patients' diseases."

Kay Feary says that students are told:

K.F. "That you must change your uniform every day and button it up to the top, some people are inclined to leave the top button open and thats not allowed, you put your hair back and you're not really meant to have a fringe though a lot of the girls do, you've to wear a hairnet and you have your hair up, and then if you wear ear-rings they must be a special type of studs.

M.T. You have small studs there, would you be able to wear them on duty?

K.F. You're not meant to wear these, just the plain studs, you might get away with them but you might be caught, just the fact that people might notice them, but you're not meant to wear jewellery."

This indicates how because rules exist, although not always enforced, you 'might get caught'. These 'rules' indicate something of the control and uncertainty that can exist for student nurses.

Standardised Equipment

Apart from the wearing of uniform, students find individual identity expression controlled to some extent as they have to bring standard items with them when they start training (9). Ruth Doyle describes the 'props' (Goffman, 1968) required of her in St. Robert's:

R.D. "We had to have a special sheaffer biro, thermometer, shoes before we came and slips and we had to have a special dress then for the school."

M.T. So in P.T.S. you had to have this list of equipment, were they checked?

R.D. Not when you came in initially but after six months going into our second block, we had to bring them downstairs, we were still living in at the time, to the library, and Miss Keogh checked them, slips and attache case were on it as well.

M.T. What is the attache case for?

R.D. The little black bag, you know, you can't bring an ordinary bag into the classroom, you have to have a brief case."

This control of appearance combined with control of behaviour means that a sameness is imposed as all must look alike, none should express individuality or let the side down. It indicates the way in which student nurses are expected to portray the professional role in their appearance, however its portrayal is not simply confined to appearance.

Behaviour

The hospital training school also attempts to control the behaviour of new recruits. These attempts at control emanate from a variety of sources. Margaret Nally, a 3rd year student describes her ethics lectures which all the time seem to be confused with etiquette. Regarding information given to patients, she states she was told:

> "...how to behave in hospital and what we could and couldn't do. We got talks on how to conduct yourself on the ward, association with patients, always to be courteous and friendly but not to become over involved or to become personally involved, different lectures on hygiene, how to present yourself, always to be neat and tidy, what you can and can't say as regards confidentiality...If somebody asks you and they know that the patient is in and the person knows that, thats okay, but if someone doesn't know, like if the patient doesn't know the person who is asking about them not to give any information, and not to speak about patients or the hospital or the policy outside the hospital if you're going anywhere or coming back from anywhere, to always behave in a ladylike sort of manner and never to be seen out in the pubs or drunk and falling around the place, never to be laughing or shouting and all this sort of thing outside the hospital and to conduct yourself in a ladylike fashion."

In St. Robert's written guidelines for new nurses state that "ladies are seen and not heard". While in St. George's guidelines the following appears under the heading of 'silence':

> "Sick people need rest and quiet - students should be considerate, avoid unnecessary noise at work, go quietly in the corridors, lifts and other public places in the hospital."

Angela O'Neill says that:

> " 'ladylike behaviour' is made an issue of here, I think". We were told when we started in P.T.S. that its not really on to go to the 'Bird & Cage' <10>, you just don't be seen going into it."

M.T. Who told you that?

A.O'N I'm not sure, probably one of the home sisters who was lecturing us."

Students find that these 'rules' must be taken seriously, Margaret Nally says:

> "I thought it was hilarious, some of the girls in our class were actually brought up in front of matron for talking to boyfriends or something like that outside the nurses' home when they were in P.T.S. you never brought anybody back as far as the nurses' home.

Sarah Evans sums up her early experiences in training:

> "We were told what was expected of us and how we were to behave. To be quiet in the nurses home...we were told to read the rules of the hospital. It frightened you, I wouldn't do P.T.S. again...I would hate to go through it again. But it was tough from that point of view, from the study point of view and pressure as well, you don't feel like an adult...I didn't."

In all three hospitals, comment could be made on personal behaviour both in and out of uniform and restrictions in the form of guidelines or rules relating to these areas existed. The very existence of guidelines or rules means that students can be pulled up or corrected at almost any time. Mary Charlton describes the restrictions on students' behaviour and attempts at its control:

> "And then a notice went up here to say that students couldn't smoke...I couldn't believe that notice went up. It's awful you know just having to go in to get a cup of coffee and having to come over here to the home to have a cigarette. I often wonder if she is trying to take every little bit of pleasure that you ever had - is she really trying to take everything out."

The 'no-smoking' rule applies to student nurses only and not to the other canteen users. These attempts at control may even extend beyond the frontiers of the hospital. Eimear Long explains:

> "Things like...one of the girls went ice-skating one night and she broke her ankle and she had to go to matron about it and matron said 'that is a pastime for secretaries...nurses don't do that!'. She tells us to go swimming and I hate it and I would much rather go ice-skating and am more interested in it...and

then she tells you when you are off-duty - time is your own and I mean in that way it definitely isn't your own. They try to control you, but I don't know if it works too well really. The last time the petrol went up...they were saying 'what are all the students doing with cars'. When you go up to matron to say you are going on holidays and she asks 'where' and you say 'Spain' say...well she says now 'have your parents been to Lourdes'. Mine actually have but this girl said 'no'. Well she said 'what are you going to Spain for and leaving them at home - you should pay their way over the Lourdes and you should stay at home and mind the house'."

So hospitals try to impose a 'persona' and life-style on student nurses; desirable pastimes, and mode of living may be implied, or as it is in this case stated openly. More overt control also exists. The following accounts indicate how the hospital training school can exert control over students' behaviour even when they are off-duty. Angela O'Neill speaks:

"I remember there was a party on one night down in the meds. residence and we were all in block, and we weren't working the next day, we were just to be in school at half eight. So we went over for a while, and oh, we were all caught, we were all killed absolutely.

M.T. And was that because you were late coming in that they knew?

A.O'N. We had signed it to say that we would be in at 2 a.m. but she found out that we were in block, we weren't off the next morning. We had to be up at half eight, for Gods sake."

These students were reprimanded because they took a late-night pass when they had to be 'in class' at 8.30 a.m. the next morning. Even in such 'borderline' cases of rule-breaking, students can find themselves subject to correction. Student nurses in these instances are not allowed to make their own decisions.

Demonstrating Professionalism

Student nurses find that they are expected to demonstrate 'professionalism'. Yet multiple criteria of its assessment exist as students find that performances in ward and school are not the only criteria of assessment, personal appearance and behaviour are also important (11). Mary Charlton states:

M.C. "This is only what you hear, there was a girl in the set ahead of us that was asked to leave because she wasn't professional enough...she was told that she didn't look professional and she

didn't act professional, well, I suppose really her school grades did come into it but I think thats what I heard, the way it was worded to her.

M.T. But how do you know whats professional?

M.C. To me its the way you act, not that nurses are meant to do such and such because they're a nurse, but I think maybe that they have a standard to reach maybe...

M.T. But in terms of what?

M.C. Personal behaviour really, even attitude as well, to some things, but you'd often find the standard that matron or the principal tutor would want you to have it certainly isn't the standard that you would want to have yourself - they kind of have it way up in the clouds...For example, we're in class and there is one of the girls who has really curly hair and she had it all down, and she was told that it wasn't the standard of a nurse to have her hair that way...it was just in curls, very curly...

M.T. She wasn't in uniform?

M.C. No, she wasn't."

Students are aware that 'professional' standards are expected. Accounts suggest that students realise that appearance and general demeanour are an important aspect of 'being professional'.

Paula Jennings notes:

> "Two girls...were threatened in our class...they seemed to be getting into trouble for nothing; I don't think it was the work because one of the girls was always getting near top marks in the assessments when we started and then when she went out on the wards everything seemed to go against her. - the pair of them have had trouble with one of the assistant matrons, and it was all over appearance maybe and there was one case when she <the student> was running around with everything on a tray <and the assistant matron met her and said> 'you would think you were a common waitress' and this sort of thing would be said...that was one of her favourites! But it all starts with things like that and then when they come in to do an exam they fail and it seemed actually far fetched and they have failed their exams and then they are brought before matron."

These accounts suggest that multiple criteria of assessment exist as overlap between work, school and leisure exists (see pp.215-219). They indicate the way in which a 'total institutional' context permits and even intensifies this type of evaluation. Goffman (1968, p.11) states:

> "A total institution may be defined as a place of residence and work where a large number of like-situated individuals, cut off

> from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life."

In such contexts, students may find that one thing can lead to another and hence they try to avoid notice (see ch. 5). I am not suggesting that the hospital training school is a total institution (see pp. 115,153), but suggest that Goffman's model is a useful way of making sense of the experience.

To get their message across and to ensure conformity, hospitals may issue a series of written instructions and directives to new recruits. Many of these directives relate to the acceptance of a particular mode of behaviour and set of values. If they fail to comply students are warned that they may be penalised. One 'guidelines' pamphlet includes details of action to be taken if students prove unsatisfactory and there is emphasis on a ten month probationary period. Even after the probationary period it indicates that training may yet be terminated for a number of reasons including 'mistreatment of a patient', 'professional negligence', 'gross insubordination' and 'any other unbecoming conduct'. It further indicates the need for absolute obedience and loyalty and suggests that if the new initiate disagrees with this she should leave. Finally, the 'guidelines' pamphlet suggests the need for selflessness and self sacrifice as the student is forewarned that personal needs may at times have to go unsatisfied. Loyalty to the hospital and the established hierarchy, obedience and self-sacrifice are all stressed. These emphasis convey to the student nurse her place in the order of things; who has authority; who is the prime mover; and the order of the hierarchy. In a handout entitled 'The Ethics of Nursing' the student is also told how her loyalty is important as is her obedience and selflessness. It would seem that the hospital is interested only in those who will guarantee the continuance of the existing structure. That the student's individuality/personality is unimportant, is exemplified in the rules with regard to appearance and

behaviour both in and out of uniform.

THE STUDENT NURSES' STATUS IN THE HOSPITAL TRAINING SCHOOL

As indicated, students have conceptions of the status of nursing before they commence training. As training commences they come face-to-face with their own status and the status of nursing in the hospital training school. Status while not unrelated to the market situation refers to the degree of social esteem that is bestowed on an individual or group (Berger and Berger, 1976). Weber (1971, pp. 251, 255) says:

> "...classes, 'status groups' and 'parties' are phenomena of the distribution of power within a community...<these> 'status groups' hinder the strict carrying through of the sheer market principle."

For Weber an occupational group is also a status group as he applies the term social status to:

> "...every typical component of the life fate of man that is determined by a specific, positive or negative, social estimation of honour..." (Ibid. p. 256).

Hospitals are very 'status conscious' organizations with outward signs of rank and position visible. Uniforms are features of such institutions - very few escape this uniform e.g. transitory visitors like visiting consultants or patients' visitors. Without her uniform indicating her status a nurse has no place in a hospital. Caplow (1972, p. 398) states:

> "...bureaucratic structures come to rely more and more upon formal position. The uniform, not the man, is saluted; duties are ascribed to the office rather than the officeholder, and people are designated by position rather than by name."

and that the

> "...layman cannot judge competence of a physician...and is therefore forced to respond primarily to an occupational label rather than to a set of individual characteristics."

In the hospital training school this is further extended to all who interact; roles and status are ascribed - this ascription and its outward show in the occupational label and uniform precludes individuality and

negotiation of interaction, thus helping to maintain the existing order (12).

All members of the nursing staff wear a uniform - this in one way or another will indicate their status in the hospital hierarchy (13). In nurse training immediately she arrives in the hospital the new recruit is categorised and labelled. She is no longer a young woman but a nurse and this labelling will set the scene for all future interaction. She is called nurse even before she has donned her uniform and everywhere she goes in the hospital training school she is labelled with her new identity. Davis and Olesen (1963, p. 94) state that: "In structural terms the nurse makes the transition from a kind of pluralistic, heterogenous society...to a guild like association of apprentices." Within this hierarchically segregated organization, one's status is highly visible. Only P.T.S. nurses wear name badges when in mufti so their status is visibly labelled to those outside the classroom unless they remove their badges once clear of the school buildings. One nurse (St. Paul's) remarks "everyone knows you're just P.T.S., even in the canteen" and in St. George's P.T.S. nurses are allocated a certain place in the canteen to sit, where again I am told, "everyone knows you're P.T.S." On the possibility of disobeying the 'no smoking' rule in the canteen, which affects only students, Maire Cummins a post-registration student says:

> "Oh, you would be brought to matron over that! If a tutor saw you she would bring it to matron, even the catering assistants would report you I'm sure..."

In this hospital students' status is so uncertain, Maire suggests that catering assistants may report students for 'rule-breaking'. Asked how she felt about being on the wards Ruth Sweeney states:

> "I think you stick out like a sore thumb - everyone knows you are P.T.S., I couldn't wait to get out of the P.T.S. uniform...Next week is our last time to wear it, then at least people won't be looking at us as much.

On the visibility of P.T.S. status Eva Lane said:

"We have a special P.T.S. uniform for the first nine weeks when we're on the wards so everyone knows we are really new and now when we go on wards we won't have any band whereas the girls who are six months ahead of us have an orange band, and they're 1st years and then the 2nd years have green bands and the 3rd years have a brown band so we won't have anything until September."

Rita Cooney justifies it in the following way:

"...if everyone is wearing the same thing, you would never know who is who. Bands make you stand out a mile. If you see a brown band you say - !oh, she's a senior, she'll know everything'."

For this student it is the ninth week of P.T.S. and she is already aware of and justifying rank and status, despite the fact that it takes from her own status. Maire Cummins, describes this lack of status and what it can mean in real terms in the course of the everyday life of the hospital:

"...a couple of months ago when the new P.T.S.'s were in block after being on the wards, and they were queueing up for lunch too and we were sitting at the long table at the back of the canteen, and I saw the catering supervisor stand up and tell those girls to stand back when the principal tutor came along."

Peter Finnegan, a post-registration psychiatric trained 2nd year states that in nursing:

"As you gradually move up the hierarchical ladder, when you reach third year, you are almost treated as a staff nurse a few months before you do your finals, but when you're P.T.S.'s people have to let you know you are P.T.S.'s. As you gain in authority, you are treated better by authority."

This male nurse as a post-registration student did not have to go through P.T.S. and started general training as a second year, yet, an awareness of the lack of status and regard for P.T.S. nurses clearly came across to him. Student nurses' perception of the hospital hierarchical structure is discussed further in chapter 7.

The following remarks sum up the feelings of one nurse at the end of P.T.S. speaking now from the vantage point of a second year. Asked if she felt people expected P.T.S. nurses to know a lot, Rachel Corrigan replies:

"Its hard to say, but you don't know anything - you come into a big ward and granted you know what you learned in the nine weeks but it boils down to nothing, even if you have worked before, because everything is done so differently here that you're at the mercy of everybody, even the cleaning women! I don't mind that

feeling, you are way down anyway."

On the wards, students encounter a hierarchical system of work organization (discussed further in chapter 7) in which they feature in the lower echelons and this adds to their conceptions of status and their fears. Fiona D'Arcy says:

> "I think it is an awful system that you are so terrified that you have got to go by the book in every respect because you are terrified of what they might do. You are anxious to do well but I think if you are being told all the time you are expected to get this and expected to do that and you are no good if you don't do this, you are bound to get the attitude that makes you feel scared."

Goffman (1968, p.46) notes:

> "Given echelon authority and regulations that are diffuse, novel, and strictly enforced, we may expect inmates, especially new ones, to live with chronic anxiety about breaking the rules and the consequence of breaking them."

Thus, indicating something of the outcome of aspects of the hospital training school experience, i.e. students lack of status and the uncertainty with which they may live.

Segregation

Davis and Olesen (1963, p.94) suggest that on arrival in hospital, student nurses become aware of the 'cordoned-off, proto-professional' orbit in which they exist. This is also evident in the present study. Not only on the wards do student nurses find that they have little to do with other grades and occupational groups (see ch. 7) but, they find that in dining areas and recreational areas, associational boundaries are drawn along occupational and hierarchical lines. Accounts suggest that hierarchical arrangements and spatial distancing are transferred from one area to another. In discussing contact with staff nurses, Maria Fox says:

M.F. "It depends on the staff nurse - some staff nurses here are actually given out to for fraternising with the students! It sounds very silly but they have been. Some staff nurses like of don't forget they have been once students and you work together and they are great to work with and make a very good team and other staff nurses have their staff nurse duties and they go and do them and you go and work.

M.T. But where would you have got that idea - would staff nurses have got that idea - would staff nurses have told you that?

M.F. Yes, newly qualified staff nurses - well just staff nurses attitudes change when they first qualify. You knew them as students and you got on and then a year later they would barely say 'hello'. One staff nurse said to one of my classmates - she had been told sort of - 'keep back from the students' but I wouldn't say that they are actually told but it just happens."

Some of this segregation arises out of nothing more than self-segregation, as students are subject to subtle sanctions. Separate dining areas are no longer reserved for different grades (apart from some P.T.S. groups) yet, at a glance in hospital dining areas, segregation is visible. Eimear Long reports:

> "All the doctors sit with each other and all the nurses sit with each other, and it's basically not right! Not that I am about to revolutionise it or anything! I am not about to go and sit at a table with a doctor, but it's not right why the hell shouldn't there be good staff relationships between the doctors and the nurses."

Consider the following account of interaction with medical students. Kay Feary says:

> "We knew all the medical students there last year but that didn't go down too well, I think, and we only knew them from outside really, a few of the girls are from Dublin and a few of them are too...we found we couldn't talk to them here at all, not in the canteen. Ask any of the girls here, they would be embarrassed to talk to students here. People would be watching,..."

In the hierarchical, occupationally and sexually segregated hospital training school, crossing occupational and hierarchical lines is discouraged and students feel such activity is subject for comment. This segregation serves to depersonalize student nurses.

Depersonalization

Kay Feary suggests that students' personal selves have no place in nursing; she says:

> "You wouldn't mind so much if you were given credit for what you did but you're not...we could come on in the morning and be told you have to do nights from tonight, and your twenty-first could be that night and it wouldn't matter, you would have to go on...little things like that...they demoralise you..."

While Mary Charlton suggests a similar experience:

> "When you get sick or that you're put into the sick-bay and I was over there just before Easter and I absolutely hated every minute of it, because they were in and out all the time and they knew so much about you from reading your chart although I had no objections,there was nothing in the chart that would have bothered me. Just the fact that they could come in at any time and matron was in and she was asking me how it happened...I had a fall and a cut became infected, that was all and I couldn't walk, and how it happened, and you ought to be more careful and go out and buy myself a pair of shoes that would cost me forty pounds and not these cheap ones and things like that...I just felt so indignant why should she come in and tell me what sort of shoes I would wear, when its part of me what I wear..."

Goffman (1968) has indicated how inmates in total institutions experience mortification as the admission process and aspects of the inmate life affect self-concept. In indicating how this occurs he cites Lawrence (1975, p. 196) stating: "You require the gentlest touch to interfere with a poor man's person and not give offence". Goffman's (1968) work has implications for student nurses' experiences. In the above account Mary Charlton suggests an almost personal attack upon her self. In other instances student nurses feel they do not exist as 'people' in the eyes of the organization (see p.258). It is as though they find that at times they have exchanged their previous social roles for that of the nurse's uniform. In this way, students' experience mortification and depersonalization, as a dismemberment of the self of the new initiate takes place. In this respect, Goffman's (1968) model of the total institution is most helpful in analysing students' experiences. It is only within the 'total institutional' context of the hospital training schools studied that students' accounts presented in this thesis can be understood (see pp. 153-156).

SUMMARY

This chapter indicates that the nurse commencing training has imagery associated with the idealized view of nursing. This imagery is often gleaned from stereotyped images of nursing, part true, part false. Student

nurses use this information to present themselves at interview as they attempt to give the 'right' answers and present the appropriate 'front'. An air of 'no guarantees of right of entry' pervades, as students with good academic results are interrogated as to their 'real' interest in 'real' nursing and the student with poor academic results is asked, 'what makes you think we should take you when we have students with six and seven honours outside?'

Even acceptance and admission to training provides no guarantees as some students undergo an extended probationery period while awaiting the signing of contracts. In one hospital the only surety is that while the contract may not be signed before nine months of training has been completed, it may be signed considerably later. The 'on trial' aspect is emphasised to the student both before and after acceptance and admission to training. Once in the hospital training school, students' willingness to serve is again tested as in a process akin to role stripping they learn the insecurity and lowliness of their own position - they are probationers and 'on trial'. As part of the test their selflessness, obedience and loyalty both to the physician and the hospital, is required. They are also expected to demonstrate other aspects of the professional role exemplified in 'ladylike' appearance and behaviour. Students find the imposition of 'professional' standards means that both behaviour and appearance are regulated. There are rules covering behaviour during 'on' and 'off duty' hours, and as some students found, expected behaviour covers areas one might assume are 'backstage' (Goffman 1971A). This can give rise to uncertainty. In the course of their probationery period, students learn their place in the hierarchical order of things and experience a resultant lack of status. In this setting segregation occurs and student nurses experience depersonalization as, at times, accounts indicate a negation of their personal selves.

DISCUSSION

The foregoing accounts suggest that the projection of an idealized image of the nurse (Olesen and Whittaker, 1968, pp. 63-4) is very real for student nurses in the three study hospitals. Olesen and Whittaker (1968) suggest that the components of this idealized image are all outward signs of the behavioural components of the professional role; facilitating the patient's expectations and consequent patient-nurse, nurse-nurse, and doctor-nurse interaction. They also serve to socialize the nurse and reinforce her traditional image and set the format for her position in the hospital structure. I suggest the effect is maximised as the hospital training school exercises authority over students as they are required to live in for an initial socialization period (see ch. 5).

The new initiate desires to belong, she has started training highly motivated probably because she has 'always wanted to be a nurse' (14). To assist her in 'becoming', it seems that the hospital training school structure provides her with a model and series of controls and checks to ensure her compliance. Dingwall (1977, p. 48) notes the problem in his study of health visitor training when he says:

> "The newcomer's actions are unpredictable, since their orienting principles cannot be safely assumed. This may be particularly important if the newcomer may be taken to be representative of the collectivity or called to join a team performance by collectivity members (Goffman 1971; 83-108). For example, there is a need to make sure that health visitor students do not let the side down to the public or the other occupations."

He goes on to say that since control over public performance is limited, ideologically and structurally that homogeneity must be achieved in more indirect ways, he suggests by explicit instruction regarding "the kinds of knowledge which health visitors take for granted". Dingwall says that this is achieved through a series of lectures and tutorials and through

assessment procedures (Ibid. p.48).

In its model, the hospital training school outlines in its guidelines and rules, the behaviour expected from the student nurse commencing training. In this study, many student nurses seem to have anticipated expectations and to this extent a certain amount of 'preaching to the converted' takes place. As in Goffman's (1968) institution where inmates and staff have different goals, so student nurses and hospital matrons may have different goals. However as far as the prøspective student is concerned, the hospital matrons' satisfaction with her can be the means by which she can achieve her aim of becoming a registered general nurse (R.G.N.). In this case, acceptance of hospital rules and order can be seen as realistic, opportunistic and strategic if such goals are to be realised. What prospective students fail to take account of is the continued uncertainty once training starts; the continuous and 'total evaluation' which proceeds throughout training as the nursing career progresses. Such evaluation relates to: personal behaviour, appearance, lifestyle and (as will be seen in chs. 6 and 7) transmission of knowledge as well as nursing work, as the hospital training school focuses on the 'total evaluation' of the person. Dingwall (1974A, 1977) also suggests the existence of 'total evaluation' in his study of health visitors and he relates it to the emphasis on 'accomplishing profession'. As Olesen and Whittaker (1968) and Dingwall (1974A) suggest, control of behaviour and appearance may be the embodiment of the professional role. To uphold 'profession', young women are needed who are 'responsible' and 'willing to serve'. Accounts in this chapter suggest a similar emphasis on a willingness to serve and on the ability of the potential recruit to take responsibility (see pp. 93-94).

If one was to do as Dingwall says and treat profession as a 'members' concept', then the accounts presented in this chapter can be seen as a

demonstration of the meaning of profession in its practical usage by the profession itself. It (profession) is demonstrated by students as they try to exhibit to those in authority "that they are on a par on all levels" (sic). As indicated this demonstration with its depersonalization can cause tension and anxiety. The demands for such exhibition can probably be best understood in the light of the ambiguity and soul searching among nurses as they seek to identify a nursing role (see ch. 1). This emphasis on transformation can be seen as an attempt at what Dingwall (1977) calls 'accomplishing profession' (see ch. 5) - I would suggest that it can only be understood in the light of the ambiguous (semi-professional) status of nursing. Components of 'profession' to emerge include notions almost of vocation as students must demonstrate their willingness to serve by the acceptance of their alloted place in the hospital. Societal images of nursing prepare them for its acceptance. In some cases, the hospital provides directives with regard to 'props' (Goffman, 1968) in terms of uniform, acquisition of particular items for personal use e.g. pens, brief cases etc. and where props cannot be directed, presentation is controlled by rules relating to dress, appearance, behaviour and activities. I suggest that this aids the transformation of the new recruit. As well as assisting the student to 'accomplish profession', these practices also induce a conformity and I discuss this in chapter 5. As Dingwall (1977, p. 124) notes for the health visitor:

> "Its not enough to pass written academic assessments - one must also pass an evaluation of one's total person as revealed in one's everyday activities."

He continues: "A good health visitor has certain kinds of qualities" (Ibid. p.125). I suggest that to get accepted for and to be successful in general nurse training one must demonstrate that one is capable of 'professional behaviour'. Carpenter (1977, p. 172) suggests that the autocratic management of early nursing was;

> "a strategy based on the single minded pursuit of an absolute value, rather than on the 'rational' weighing of alternatives in the light of their utility. In other words, the conservative infrastructure was designed more to help achieve and maintain an occupational community than to make best available use of labour resources...It ensured, however, that only those with the highest levels of motivation reached the apex of the occupation, guaranteeing the survival and transmission of the occupational ideals from one generation to the next."

In Ireland today, I suggest that in the absence of role definition and of clearly defined status in nursing, nurses fall back on personal attributes and an array of external expression in paraphernalia and behaviour to demonstrate their professionalism, as did Carpenter's nurses. They do this in a futile way as they get trapped in their own rhetoric of 'keeping a place for the right type of recruit v. the better educated' who might not 'accomplish profession' as they desire (15). This further adds to nursing's ambiguous status. Etzioni (1964, ch. 7) discusses the relationship between selection and organizational control. He suggests that careful selection processes may leave institutions with a lesser job of socialization. I suggest that this is what surrounds the questioning of students at interview as hospitals carefully pre-select those who are likely to 'accomplish profession' in the desired way. The rules regarding appearance and behaviour that meet the new initiate on her arrival in the hospital confirms her expectations of the hospital training school's requirements.

To conclude, this chapter indicates that the way in which profession is accomplished in nursing, is through 'total person evaluation'; it contributes to the mortification of the student nurse and she experiences depersonalization and uncertainty. The next chapter presents accounts of experiences of residential life in the hospital training school and discusses ways in which a uniformity of existence is imposed.

FOOTNOTES

1. Hanrahan (1968) also showed in her study, that nursing in Ireland tended to attract recruits with an educational standard equivalent to a vocational standard. It would appear that nursing in Ireland, tended to recruit girls with a high educational standard and on the basis of this evidence, it was tentatively suggested that nursing as a career was not the only alternative profession open to these respondents. Nursing students in Ireland tend on the face of this to have an overall higher standard of general education than student nurses in Britain. As indicated in appendix 1, in Irish society, the tradition among women (especially middle class women) to take up nursing as a career is very strong. Unlike Great Britain competition for entry to training is strong; apppendix 1 also includes details of ratios of applications to places available in nurse training.

2. Information relating to students' ages, family background and education is included in the student profiles in appendix 1VA.

3. Male students rarely commence a nursing career in general training. The Working Party Report (1980) indicates that low numbers of males apply for basic general training. A tutor noted that in five years teaching she had only ever had one male student in P.T.S. Men usually (and in small numbers) undertake general training on secondment.

4. Much controversy and resistance currently attends attempts to introduce a central admissions bureau, with proposals for centralized applications and centralized interviews.

5. As indicated earlier, male nurses are usually on secondment and return to their 'seconding' hospital, usually psychiatric, after training. Perhaps for this reason, they do not have to be vetted so vigorously for their eighteen month period of general training.

6. An Bord Altranais September 1986; this is now discontinued.

7. As indicated in appendix 111A, the length of this living-in period varies from hospital to hospital, in some cases being as little as six months, in others as much as two years.

8. To matriculate on the results of the Leaving Certificate, candidates must present at least six subjects selected according to faculty requirements and must obtain grade C or better in two subjects on the Higher Papers (honours) and grade D, or better, in the remaining four subjects on Ordinary (Pass) or Higher Papers. In practice, because of competition for entry to courses, higher entry requirements may apply. This has occured only in the past two years.

9. This must be considered in the light of the uniformity of existence described in chapter 5. The standardization and uniformity of existence is discussed more fully in chapter 5.

10. A local lounge bar.

11. The proficiency assessment form includes a section on professional behaviour, and both registration (part 1) and the final examination schedule have a section entitled 'Certificate of Character' (see appendices V1B and V1C).

12. Chapter 5 indicates the student nurse has no status or existence outside her alloted nursing role as a uniformity of existence is imposed.

13. There is a distinction in uniform first of all between trained and untrained and a further distinction between students. By means of a coloured name badge, belt or band their level of training is indicated, except for P.T.S. nurses who wear a distinctive white dress for ward visits during their nine week introductory course. This dress marks their position most visibly. Nurses in P.T.S. while in class wear mufti but also wear their hospital name badge which has the distinctive colour of their year. Between trained staff distinctions also existed, as matron, assistant matron/nursing officers, sisters, and staff nurses all wear different and distinctive uniforms.

14. Goffman (1968, p.24) points out that the military cadet's entrance is voluntary (Dornbusch, 1955) and that this means that "...the recruit has already partially withdrawn from his own home world..." The majority of students in this study had 'always wanted to nurse', like the military recruit, their entrance to training is voluntary, consequently they are likely to be highly motivated in their chosen occupation and strongly desire to 'stay-the-course'.

15. The current controversy surrounding attempts to introduce a central admissions bureau could also be considered in this light. Hospital nurses wish to retain control over student selection for their training schools.

CHAPTER 5

A UNIFORM EXISTENCE?

RESIDENTIAL LIFE IN THE NURSES' HOME

INTRODUCTION

This chapter presents student nurses' accounts of residential life in the nurses' home. It deals with the way of life that is imposed on the student nurse through compulsory residence in the nurses' home. I suggest that the chief message transmitted to students and constantly reinforced through this institutional existence, is the idea of 'vocation' - that nursing is not a job like any other and all aspects of one's existence may have a bearing on one's ability to nurse. It seems that personal life and behaviour become the object of continuous scrutiny through residential life in the nurses' home. In this chapter aspects of the student nurses' experiences in relation to life in the nurses' home and a uniformity of existence are considered as they relate to control, discipline, lateral life roles, and the hospital training school as a caring community.

AN ABSENCE OF CONTROL

As indicated (ch. 4), students learn from the commencement of training, that they are not responsible adults. Admission procedures exist whereby students, accompanied by a parent, meet matron. At this meeting contracts may be signed and a talk given on the hospital's rules, students' new responsibilities and the amount of hard work necessary on their part if they are to stay the course (see p. 100). Goffman (1968) suggests that admission procedures may mortify or debase; in this study many students

feel humiliated at initial meetings as they are told 'how hard they now must work because, after all, their examination results are not so good'. At such meetings, new students may, like the inmate in Goffman's total institution, be forced to humble themselves, i.e. the forced deference of the total institution, as they learn who is in authority and to whom they must show respect. In this way, students become aware of their own low status in the institution. At these early encounters, and there may be more than one, as students meet matron and later the principal tutor and their tutor in the classroom, students will also find that they now need permission to perform certain activities i.e. move out, stay out late, remain out overnight etc. Some students likened their experience of the nurses' home to that of boarding school. Mary Kelly says:

> "I suppose it was easy for me to settle in the home. I was used to restrictions, much more so than here but I think boarding school is different. I suppose you accept these things when you are in school."

In St. Robert's, Paula Jennings explained how, when checking into the hospital and the nurses' home, parents were expected to be present and to sign a form to say that they would be responsible when their daughter was 'signed out' to certain designated addresses. At interview this student recalls what matron said:

> "...she said to me 'well you can stay out at night but we have to have names and addresses where you are going to be staying'..."

Sheila McCann, now at the end of first year and living in a flat, points out that:

> "Your parents had to see your flat and write a letter saying they had seen and approved it...I know my dad wrote anyway...my mother doesn't say much but dad...I think since dad came in here the day I started - I don't think he would have believed it was so bad but when he came he couldn't believe it! He knows that I am well able to take care of myself."

Once they commence preliminary training school, nurses have to be resident in the nurses' home for a period of six to twenty four months. The nurses' homes are located in the hospital complexes, often

necessitating passing through hospital departments to gain access. In some cases they house changing rooms for non-resident staff, staff sittingrooms, resident sisters' quarters, assistant matron's office, home sister's office, and a clinical teachers' office. To enter the nurses' home in two hospitals it is necessary to pass by the nursing administrative staff offices. There is no way a student in any hospital, once in the nurses' home, could feel that she is not under the watchful eye of senior staff. Ruth Sweeney says:

> "In the beginning I felt very restricted. I have never been to boarding school, I was at home all the time."

She goes on to link the pressure she felt to the very rigid discipline and control of P.T.S. Many of the student nurses had been to boarding school and this they felt helped them to fit-in and accept the discipline of the nurses' home. Carmel Macken says:

> "I went to boarding school before I came here and still, much as I adapted to weekly boarding school and that, I felt more restricted here...I was dying to get home.

Mary Connolly states:

> "I hate having such little freedom and privacy. Given the choice I would have found a flat after a month but we must wait for six months. The main problem is getting in late at night as the doors are locked."

Rosemary Armstrong says:

> "You can't go here, you can't go there unless that happens to be on the night that authority have decided that you can have your late pass because you are not working the next morning! Basically speaking...you are not allowed to make a mess of things. You are not allowed to make your own decisions while you are staying in the nurses' home, you can't because you have got to follow the rules in that particular area!"

Rita Cooney contrasts life in the nurses' home with life in a hostel where she lived before starting training:

> "Well I mean you can go out until 11.30 and there is no one stopping you but there is a restriction after 11.30. I was in a hostel before that and the difference was that I had my late-night key and I could get in anytime I liked."

An assistant matron explained to me that nurses could not have keys to the

nurses' home for 'security reasons'.

Some students accept that the hospital acts in loco parentis and that they themselves are not allowed to take responsibility for their own actions (see p. 140). Susan Reid says:

> "I think it would be nice for people to live in flats around the area but I suppose this sounds awfully sort of goody-goody'ish, the discipline I get from it - I suppose maybe thats what they're trying to pass on."

Ruth Sweeney made a similar remark in relation to the heavily structured classroom day saying she was lazy and needed the discipline:

> "It's handy in that you just get up in the morning, have your breakfast and go to school...I think in a way it makes it easier for starting off because if you have to be in the wards at half seven, it's going to be difficult to find a flat or even if you do find a flat, it's going to be difficult to get up and tidy up your whole flat as against one small room and get out on the wards. It does make it that much easier for all your odd hours. If you're on night duty, well when you're at first on night duty, you'll at least try and get some sleep in."

Kay Feary says:

> "I think that for a lot of girls that have been living at home all the time and their parents might have been very strict on them and if they are allowed so much freedom they may go to the other direction altogether and be up to 3 a.m. every day. You have to come in at a certain time to be able to work because if you are tired you won't be nice to the patients, you may be cross and they need to be cheered up and so you have to have a certain amount of sleep."

However, whether they desire to or not, students in the early days of training are not allowed to make some of the most basic decisions for themselves.

Surveillance

Life in the nurses' home also means that students are exposed to constant surveillance. Little 'backregion' space (Goffman, 1971A) exists. Eva Lane explains:

> "We have keys for our rooms but now the reception has all the keys as well so they go up during the day. There are some checks every now and again to make sure your rooms are tidy. Well they are swept and cleaned out twice a week but matron for instance can go up and open all the rooms to check."

Students are aware that they are likely to draw attention if they do 'anything wrong' in the nurses' home. Kay Feary reports:

> "Say if you break anything or if you leave your clothes all thrown about and your room really untidy."

Ruth Sweeney says:

R.S. "We have been warned to keep our rooms tidy and if its not tidy there will be a note left for us and if you get two notes...you are out sort of.

M.T. Do you think they mean it?

R.S. I don't imagine they do, I would say it would have to be in an awful state but I know some women come in to clean it, it's not just totally my own. Other people have access to it."

Only a few students gave personal examples of checking but all seemed aware that they could expect this surveillance. Ursula Dwyer says of the surveillance in the nurses' home:

> "While I wouldn't want to go out all that often, you had to sign out and in, the exact time you came in or if you didn't come in at that time, you had to go down to matron's office...you had this awful sense that you were being watched all the time...it was worse than school, but you couldn't really put your foot outside the door without somebody noticing."

All students expressed a feeling of surveillance, regarding her relief at escaping from it, Sarah Evans says:

> "Everyone is kind of looking at you and if you put one step wrong thats it!...I know someone now...they were messing or doing something out there <outside the nurses' home> and someone saw them from the window over there and they were called over and given out to. You just feel they are watching you all the time. I better watch myself! Now on Friday in the classroom, particularly in P.T.S. everyone just says 'thank God it's Friday and we are going home today'."

In relation to this aspect of the nurses' home Rita Cooney a P.T.S. nurse says:

> "... it wasn't very hard for me but some people have been out of school for two years working or something...I am so used to it now that if someone came around the corner and I was messing I would probably say 'Oh! God she caught me again' and that's it! Some people say 'is matron around the corner?'...different people find it different."

Carmel Macken who has just moved into a flat after a compulsory eighteen

months in the nurses' home observes:

> "In a flat you have more freedom really. Usually in the nurses' home too if you made noise someone would be up tapping... The nurses' home was great in the beginning, you didn't have to worry about things like eating, it was all there for you..."

One of the lessons of the nurses' home is exposure to hospital authority. Angela O'Neill describes her position:

> "We were on the 3rd floor which is unfortunate, the 2nd floor was the infirmary, and where the older people lived, like the supervisors and junior ward sisters that didn't live out. So we were sleeping right above them and we used to make a hell of a lot of noise, you know, and they used to be always ringing up saying they were going to complain if we didn't go to bed, and things like that."

Fiona D'Arcy recalls:

> "We had the matron over to us in 1st year because we weren't keeping our place tidy or something and then we had a lecture with her."

Ruth Sweeney, still in P.T.S., repeats what has been said about why nurses should not spend too much time out; it indicates the subtle control exerted, no firm rules, just the implication that 'you're watched'. The following indicates how this is conveyed:

> "...they said if you constantly take too many late night passes it might be queried,<that> you are spending too much time away from the hospital, that you are not interested in your work.

Students in the nurses' home, as on the wards, find that the cleaning lady or porter may report on them to higher authorities. Rachel Corrigan describes one way in which surveillance is practised:

R.C. "You have to go to the porter on the main door and he lets you in and you have to sign this book at the time you come in and if you don't have a pass you shouldn't be out.

M.T. If you don't have a pass, would you be able to get in?

R.C. He would let me in but I would have to sign... and if it was checked...I'm not sure whether they do check it or not.

An uncertainty is created for students as they never know when authority will be exercised. Students, when asked, agree they can take a chance and stay out without signing, but they just might be checked or missed and they have too much to lose by breaking the rules. Joan Burke says:

"They don't check everybody's room every night. That is the only way they find out...well we have never been checked so far that we are in our rooms but there's the receptionist alright who comes up every night at around twelve to make sure that all taps and things are off and the main lights are off but like we can go and turn them on again when she goes down. I've never met her anyway although she does do it definitely."

Fiona D'Arcy, who lives out, explains that a friend from home is in 1st year and she had asked her to stay the night on a number of occasions. She reported: "But she won't, she's so afraid she'll be caught...I don't blame her." Students in all hospitals reported similar constraints of residential life. Paula Jennings recalls:

"They used to check the room - they were meant to do it every night but they would do it four weeks on the trot and then a gap...<We were> sitting up watching telly, the assistant matron who is two floors up, and she came to us a few times to give out to us. I mean you are off duty. You couldn't breathe but she would give out to you...

M.T. But could you sit up until after 12.00 watching telly or things like that?

R.D. It depended. Night sister comes around every night to check the home and it sort of depends which of them is on. I don't know about weekends because I always went home so perhaps they were a bit more lenient then."

Thus, some constraints are unpredictable as it depends on 'who is on'. In St. Paul's, nurses shared rooms and did not have keys to bedroom doors, they only had keys to wardrobes! In all hospitals, others have access to rooms and can report for untidiness, rule-breaking, etc.

Ruth Sweeney indicates the hierarchical encounters that can occur in the nurses' home:

"Well, I don't mind it really <living-in> because I knew all along that I would have to but sometimes you get rather annoyed when you get caught doing something when you didn't honestly think you were doing anything wrong, you know. For example, one day we were coming down in the lift, two days before, I had been informed only six people in the lift, so that was grand, six of us piled in, and didn't keep the lift waiting or anything and on the way down another nurse got in so there was seven, and at the bottom we met a sister and she nearly killed us, she said we kept the lift waiting for five minutes up on the twelfth floor...Sister, we said, we didn't get in at the twelfth floor, it was the tenth, then it was the tenth floor you kept it waiting at...we hadn't kept it waiting at all and she killed us, and it

wasn't even brought up that there was seven in it..."

I suggest that this encounter but for the extension and presence of hospital authority, would hardly warrant comment; it must be seen in the light of the student's low status and the 'on trial' aspect of her position. Student nurses, it would appear, have little access to a 'backstage' area as a place for private behaviour and have little control over events. Lack of privacy and control is also a feature of one's lack of status in an institution. As a result of surveillance and the encounters described, students' lack of power is emphasized. I suggest that these accounts and those in chapter 4, indicate that student nurses experience lack of privacy and control on a daily basis in the hospital training school.

Behaviour

Residence in the nurses' home also gives hospital authorities another opportunity to control aspects of behaviour as rules regarding community living must be imposed - night duty nurses sleeping in the nurses' home need silence, thus reinforcing the need for quiet 'ladylike' behaviour both on and off-duty (see p. 105). Senior nursing staff can signify acceptable standards of behaviour to students. Ursula Dwyer says:

> "There was a home sister, I remember there was one in P.T.S and she would watch out to see if you were going to Mass in the little church and she'd say 'I don't see very many of you over there, you should all go to Mass, daily Mass, seeing as you're in P.T.S. you're off at that time! I thought it was up to yourself, I wouldn't go to Mass over there now in a fit because you're just so aware that they're just looking you up and down, any little fault and you're done for'.

Angela O'Neill, a 3rd year student, makes this reference to the general surveillance that goes on in the nurses' home and in the hospital:

> "We were in the nurses' home and we were expected, not so much expected as guided into the churches there and you all go together and this kind of thing and one of the big things about Mass here is, if you're working on a Sunday morning you're allowed off the ward for Mass. There are three different Masses and you go in groups and you try and leave the ward late, deliberately try and be late for Mass knowing that matron will

> have stopped somebody on the corridor and tell them 'you have to read the lesson' and you're told you have to read the lesson, you're not asked would you read the lesson. Actually, there was one instance when a girl came off night duty after a really tough night on a really busy ward, I think she had two cardiac arrests or something like that, and she came off and her uniform was in a mess and matron asked her to read and she got up and read and after she had read, matron brought her down to the office and literally ripped the uniform from the hem up - for the state of her uniform."

These accounts indicate that any exposure to hospital authority presents opportunity for scrutiny and possible reprimands. Apart from the above, attempts are made to enjoin other types of behaviour. Consider the emphasis on 'ladylike' and 'professional' behaviour in chapter 4. This further adds to students' initial feelings that, in nursing, they are expected to be on 'a par on all levels' (ch. 4). An expectation of specific, uniform standards of behaviour is transmitted to student nurses.

The student nurses' work role and life in the nurses' home

Life in the nurses' home is clearly related to the student nurses' work role. Student nurses' accounts indicate how aspects of the life they lead therein, is related to their work role in the hospital. Eva Lane explains how the hours students are allowed to keep are determined by ward off-duty:

> "You have to be in by half eleven. During P.T.S. we all have to be in by half eleven during the week and, once we start working if you're not on duty in the morning, you can get a late night out until 2 o'clock or you could stay out for the night with a friend or something like that. But say...if you got a late pass until two, you have got to sign the porters' book when you come in or if you stay away you have to sign the book before you go and all that."

Rosemary Armstrong states:

> "You can't do what you like when you are staying in the nurses' home. You have to be back at 2 o'clock in the morning, half eleven if you're working the next morning, so therefore, there is only a few times that you could go out! Because nursing...well it is such a disciplined area, you have an awful lot of responsibility on the ward, it is basically pressurised. You have a lot of study to do, and everything is hard work!"

In St. George's, students find that if they have early duty it's impossible

to get a late pass until 2 a.m. They must be in at 11.30 p.m. However, if they're on a day off or late shift, they still must seek special permission to stay out late. As I shall indicate, the nursing hierarchical structures are carried over to the nurses' home from the work areas, further emphasizing the link between students' work role and hospital residence. Student nurses exist for the hospital exclusively as first year, second year or third year student nurses; whether they are on or off-duty, they remain student nurses. I suggest that nurses' homes are not simply convenient places of residence but are a constituent part of the hospital training school. This is further supported by accounts in the next section. Early initiation into the nursing world does not allow the student to put her nursing day behind her. She learns that a uniformity of existence is expected and that she is a nurse twenty four hours a day (discussed further pp.139-144). In the hospital training school, student nurses find that their independence is curtailed and that they are unable to exercise total control over their day-to-day lives.

DISCIPLINE AND THE NURSES' HOME

As indicated, surveillance is the outcome of life in the nurses' home. During the day, checking of rooms, reporting by cleaners or spot checking for untidyness is always a possibility. For example, in the course of a student interview in a small reading room at the entrance to the nurses' home, we were subjected to a 'spot check' by the home sister who remarked "someone's been moving the furniture around". We had simply moved a coffee table six inches nearer the wall in order to play the tape-recorder. Other accounts of such spot checks and their consequences are included in this chapter. Life in the nurses' home cannot be taken lightly, breaking rules therein is regarded as a serious offence. When observing on Simpson ward I

noted a 3rd year student nurse, who was just about to sit the state finals examination, without her 3rd year band. This student had told me previously that she had just moved back into the nurses' home because her car had been stolen and her aunt's home, where she lived, while only three miles away was awkward for public transport early in the morning. A tutor made approving remarks about her general ward and school work. When she was demoted, I talked to the student about it and her response was "I'll just have to try to keep by head high". I enquired subsequently of a tutor about the incident, to discover that the school did not know of the loss of 'rank' but she surmised that it was nothing to do with work but must be connected with the nurses' home. On following up the incident, this hunch proved correct. This finalist had lost her band because she had signed herself out in a late pass under another nurse's name, her own one late pass for that week having been used up. For this misdemeanour, this student lost her rank in the hospital hierarchy amd was left 'bandless' (like the P.T.S.), while still continuing to undertake the work of a third year student. She was told that she was irresponsible and could not be relied upon in her ward work and need not apply for consideration for work experience as a staff nurse - quite a blow given current job prospects for nurses (1).

Two other students I interviewed reported a similar incident when they were party to the breaking of a rule relating to the use of irons in bedrooms. Angela O'Neill lost her 'band' and a rise in status because of a misdemeanour in the nurses' home. She explains:

A.O'N. "This was after our first six months. We had our orange bands, and everything was going fine, and the next thing was, it was the morning of our green bands and we were coming off night duty and we decided we would iron our uniforms. We used the iron in our rooms and for that particular reason two of us were called because two of our rooms had been used for the ironing because there was no kitchen open. There are two sides to the story; ironing is prohibited in your rooms because of the fire hazard but where you are supposed to iron is in the kitchen but where are you supposed to iron if there is no kitchen open? You have no alternative, and there was no real hazard because the irons

were unplugged, but it was found out and two of us were demoted for that.

M.T. So you weren't given your green band?

A.O'N . Not for a while, we were left with our orange band... The justification for doing it was that we had broken a role of the nurses' home, and I still don't understand it, I don't believe that we should have been taken off for it, I don't think its anything to do with our nursing or...okay if we broke a rule of the nurses' home, there is something else that could be done besides actually taking it out in your work. Because your band as I see it is a sign of your nursing standard and how you're progressing through your nursing, nothing to do with tidying your room or you breaking a rule of your nurses' home...I would hate to see any girl go through what the two of us went through. I can understand that as such we were breaking a rule and I can see both sides of the story, but I think the punishment was wrong, I still do, even though we apologised and said we understood and all the rest of it...

M.T. How long did you have to wait for your band?

A.O'N. About the next month or more, when we were given it back, surprisingly...I thought she was very nice about it matron..."

Another student gives her account of the same incident. Her anger and frustration at what she sees as an indiscriminate, almost blind, unjust discipline is evident. Deirdre Kane recalls that although she was seconded to another hospital at the time, she was expected to receive her 'new band' in person. Six other nurses were in a similar position. She continues:

D.K. "We had come in to get the bands. We were told the time and we couldn't get the day off. None of us had that day off, and we had to request to work from half ten to eight instead of eight to eight. We had it split in the middle and we got it grand. So we came out anyway, six of us, and we had to iron our veils so we had to use two of the bedrooms because they wouldn't open the ironing room for us because it was so early in the morning. We asked the cleaning women and they couldn't, so we went in, three of us to each room and ironed them and left. We just dumped everything because the place was in a mess anyway, and we went off down to matron. We got a big long lecture beforehand from matron...all about how you've come this far now and not to let the standard drop, keep it up...if anything had happened there was a big lecture about that, that went on but you just take them for granted...and how going into your second year you will have more responsibility on the ward and hoped we were studying for our exams and all this kind of thing, no praise at all...

M.T. Does matron actually pin them on herself?

D.K. She does, yes, its a big deal about it. And the women in charge of the nurses' home came storming in all flustered, really flustered, and the girl with the iron said, 'I'm constantly

> getting into trouble.' Sure enough anyway, her name was called out and another girl's name, and <the woman> said she 'had something desperate to report... I'm so horrified, two of the girls have been ironing in their rooms...' It went on for about half an hour, and then they brought the girls upstairs to show matron their rooms. And the six of us from the Infirmary decided we had better do something about this so we went and followed them up in the lift, and when the lift opened, who was standing in front of us only matron and the girls in tears at this stage, on their way down. We tried to talk to matron but she just kept saying, 'get down, I don't want to hear anything, you are so rude just get down'. So we went down and were waiting for explosions and she took down our six names and told us that we were very rude and it was going to the Board of Management, that they might not be kept on, that they were irresponsible. <They> thought that breaking the ironing rule was a sign of being irresponsible on the ward...It had nothing to do with our work really...and they were unplugged...If the bands had been taken off the eight of us...we felt so awful about it all because it was our fault. I stood up again that day downstairs when we were all sitting back and tried to explain and she 'ate' me, but I told her exactly what had happened...I don't think I'll get back as a staff nurse here."

Rules are enforced as their maintenance becomes more important than individuals. This student also recognises that as she has already encountered the disapproval and notice of those in authority, this will probably have far-reaching consequences for her and she is unlikely to 'get back as a staff nurse'. Not all incidents are as damaging to a student's career. Much of the time, while incidents are no more than petty irritations, they can add to a student's uneasiness and discomfort. For example, Margaret Nally reports:

> "...another thing happened too with the veils, the way we have to do them, we found out that the easiest way to keep them without creasing was to plaster them onto the back of the wardrobe inside. And they stick when they're wet, and then you take them down, peel them down and they're really starched, they're really simple to iron and about ten of us got caught one day and we were all fined a fiver, you know, for the missions - for plastering veils on the wardrobes - honest to God. Just think like, that,...they checked our rooms at random and this just happened to be the day they checked. All the veils were up...but I don't think we'll do it anymore because of the fiver - it left a kind of powdery mark on the door. With a duster it would come off. They were going to repaint the whole wardrobe then decided to give it to the missions instead so needless to say the next time we did it, we locked the wardrobes."

In interview, Maria Carey, a staff nurse, informed me, with no reference to any particular situation, that students often lose rank (bands), and are

disciplined not for anything to do with ward work, but that when it happened it was always associated with behaviour in the nurses' home or elsewhere. Patricia O'Brien, explains how and why living-in and its importance was emphasized to her:

> "I had five months in Sweden and then I was in the Hospice but... I had to live in as they told me they wouldn't take me unless I lived in. This was gas as they told me that as I had lived in Sweden on my own for five months that I had probably lost all morals and responsibilities and all my parents had instilled in me and that is why they wanted me to live in so that they could keep an eye on me. So, therefore, I had an idea about the nurses' home even before I started here and it was just as strict about time and coming in. But I think it was a good idea anyway because we got to know each other an awful lot better. We were living with the girls for six months."

This student was aware that she was living-in, so that she would be exposed to the discipline of the hospital training school.

Recently, the Department of Health built a new hospital without a nurses' home - a controversy is now ensuing between nurses and the Minister for Health over this matter. The nursing position is summed up in the following excerpt from an interview with a matron of one of the hospitals concerned. It states that student nurses must 'live-in' to learn 'discipline'. The matron suggests that student nurses are not the same as other students or young workers who come from outside Dublin. She states:

> "A young nurse works irregular hours. She must get used to the discipline of that and of taking direction from ward sisters and senior nurses. The initial uncertainty and fear of harming a patient puts strain on a young nurse. It is also quite possible that she will meet with the death of a patient in her first days on the floor.
>
> A young nurse must also attend lectures. The nursing course is comprehensive and very difficult. It demands lots of study.
>
> The Department has suggested that perhaps a private company would build accommodation and rent it out to student nurses. This is definitely not acceptable. It would be off-site and not under hospital jurisdiction."
> (Irish Nursing Forum, 1985, p.19).

It seems to be an accepted feature that life in the nurses' home means that behaviour is under surveillance and controlled. Residence in the nurses' home provides hospital authorities with opportunity to control and discipline and to impose standards of behaviour outside of the work setting.

SEGREGATION

As indicated in chapter 4 and chapter 7, the hospital training school is segregated according to rank and occupation. Within the nurses' home, hierarchical segregation is maintained. There is little 'common territory' where trained and untrained meet in the nurses' home. In this place of residence, the hierarchical arrangements of the clinical areas are evident.

In the nurses' home, another type of segregation is apparent, as students find themselves cut-off from normal friendship circles, especially males. Ruth Sweeney explains:

R.S. "They are not as flexible as in other hospitals. I have a friend in St. Maria's <2> in Bray, and she was telling me they can have parties in the nurses' home, they can have friends in and even some can have boyfriends in. We can't even bring anybody in to the sittingroom without asking permission. You can't have a boy past the door out there. My brother was in to see my sister one day, I think he was bringing her home and he went in the door as he wanted to go to the toilet and he was given out to for coming in...you can just see people in the reception area - just inside the door.

M.T. So you couldn't have a friend to spend the evening talking to you in the sitting room?

R.S. I would have to get permission. I can see their point but it seems very restrictive, it's not like a home although they call it a home."

On receiving visitors in the nurses' home, Ursula Dwyer recalls:

U.D. "You could brinq them as far as the hall. Your brother or father weren't allowed up to see your room even or whatever, even on the day you were going in.

M.T. So men aren't allowed past the hall?

U.D. Men weren't allowed past the hall. Your mother or your sisters were allowed up and you signed a book to say who they are and they were allowed up. I felt that for people who were supposed to be fairly responsible it was a bit much!..."

The preceding account raises another issue as it indicates that nurses' homes are 'female territory'; male visitors, family or otherwise are banned (3). In one hospital, where sisters and mothers are allowed as far as the sittingroom, the clerk at the desk may question and require information about visitors. Rita Cooney explains:

> "Well they can only come as far as reception unless it is your sister or your mother. You have to try and convince the one at the desk that they are your sister or your mother."

Thus, a 'segregated' life is imposed on student nurses who are 'living-in'. They cannot easily share their off-duty time with nurses not attached to their hospital training school, unless they meet outside the nurses' home. Residence in the nurses' home provides the means whereby some degree of segregation from the 'outside' world may be imposed. This I suggest has an affect on students' lateral life roles. Angela O'Neill indicates restrictions on friendship networks:

> "You're inclined to stick with nurses. All the girls I go out with, they are all nurses and we talk about nursing all the time."

Only one student nurse interviewed was not living with her family or with other student nurses. This, I suggest, reflects the closed nature of the hospital training school community. Ruth Sweeney points out that for those farthest away from home, the restrictions have greatest effect as they find it impossible to entertain friends. She explains:

> "I could have any of my friends home if I wanted to as I'm so near but then say if you're living down the country and you can't have any of your friends in Dublin, its a little bit tough..."

Living in the nurses' home and yet feeling the need to be away from their place of work can provide students with an 'odd' life-style as they remain constantly on the move from the nurses' home, to friends, or to parents.

They do not find themselves permanent anywhere and, are 'at home' only when they actually have sufficient time off to warrant the journey. As restrictions are imposed, life in the nurses' home becomes very institutionalised for inmates as they find they can live twenty four hours a day under its roof without any contact with the 'world' outside the hospital. Rachel Corrigan, who feels that life in the nurses' home is not too bad, sums up her feelings:

> "I would never look on it as my home and that is why I am looking forward to living out. I'm going to find a flat because you're coming from work to your room here. You could literally live for a week without ever seeing outside. You go underground, especially on night duty - you come off in the morning and you go under into your room, get up at six or seven, go to wards or canteen in the tunnel. In the winter you don't have to make the effort, everything is too laid on there for you so I figure if you live out at least you get out in the air."

This segregated life in the nurses' home means that students can live their lives out within the hospital, thus reducing outside contacts and networks. This is now discussed.

THE FATE OF LATERAL LIFE ROLES

In the early stages of training, students find it difficult to keep up a life outside of the hospital because of the restrictive effect of the nurses' home. Rita Cooney gives the following example:

R.S. "You are in P.T.S. now say, and you wanted to go out on Monday night - you would have to have a very good excuse for staying out. You can stay out until 11.30 anyway.

M.T. Say there was a party on?

R.S. Not for just a party - you wouldn't get out. I got out one night because my uncle was 25 years a priest and I had to see the assistant matron and I had a letter from my mother and I did get off...usually...you have to be in by 11.30 p.m. and its not that I want to go anywhere but I feel restricted."

Ruth Sweeney points out restrictions imposed by nursing shift work, she recognises that one's life in the hospital can become one's total existence. She suggests that a uniformity of existence can arise:

"But then with nursing you can't really join a sports club or that because of the hours, if they meet every Saturday afternoon the chances are that you won't be free for most of the Saturdays. There is a swimming pool just down the road that you can go to. I haven't actually gone yet but I'm going to as soon as I start on the wards when I'll have a bit more time.

As she indicates, the restrictive effect of the demands of the hospital training school are experienced whilst in P.T.S. Ruth anticipates that she will have more time once she starts on the wards. Susan Reid feels that the nurses' home can make you lazy:

"You don't have to walk out or cycle or anything. I haven't had all that much free time but I go jogging and that is in the evenings, which I didn't do at all before I came here. But I thought I wasn't going to spend my time walking from the lift and then getting the lift upstairs, so I decided to go jogging.

Kay Feary highlights, as did many students, the advantages of living in the nurses' home:

"I would rather stay in the nurses' home for the first year anyway because it would be very hard to stay out in some place, not to know the girls first of all. You would have to know them first before you started moving out into a house. If I came up here and if I didn't have the nurses' home to stay in I could end up with people, say who work in the Bank, and I would really be out of contact with the girls from the class because you really get to know each other."

So, some students welcomed the safety and security of the nurses' home, but at the same time the majority felt the discipline was overdone and all felt they were constantly 'being watched'. Rosemary Armstrong summarises the reality of discovering what life in the nurses' home was like:

"There were some girls that were after working maybe a year. Even when I worked in Navan, I was living in the nurses' home there, it was much more lenient. There wasn't really any strict time that you had to be in at. Other girls were in flats and the next thing was they were shoved back into this institution! They had to be back in at 2 a.m. I found it far more easy to adapt because I was in boarding school for five years and because I was in this other nurses' home. From the point of view of living with other people, living in this institutionalised set-up was much easier to adapt to. What did annoy me was, there I was at 18, I was after working for a year and there I was again earning money, paying tax and everything else and I had to account for every move. I had to sign a book, I had to sign out and to sign in and I had to be in at 2 a.m. I felt totally restricted. At first I didn't really resent it because I thought...'you're lucky you're doing nursing at all' but after a while I began to think,

> this is ridiculous. Why should I be locked up as much as this? You feel like a child again...You have to have so much responsibility. Yet you can't do that with your own social life! You couldn't have friends in, you couldn't make coffee for people, if your parents were up in Dublin or whatever you couldn't say...'call out' or whatever, you could only talk to them in the reception area...you were subjected to all that. It was not very private. You couldn't have friends stay for the weekend,...anytime I had friends staying up for the weekend, if one of the girls came up from home to see me, I had to find some friend of mine who had a flat and ask her if she would mind awfully putting me and my friend up for the weekend. At that stage, your friends are at university and they can't understand it. It's terrible really because you're back to square one again."

While recognising that many people other than nurses form social friendships within their occupational group, I suggest that the particular 'living-in' arrangements in these study hospitals makes it difficult for students to make or maintain contact with non-training school friends (4).

'Leaving Work Behind'

Some students indicated how initial life in the nurses' home means that you are never 'away from work'. Fiona D'Arcy states:

> "You really feel you are on call all the time. Even though we are only a few weeks in the hospital or whatever we would be expected to go on the wards if there was a major crisis and do as best we could."

Helen Cox remarked that one of the things she hated about the nurses' home was that, when on late duty, she woke up to find herself in the hospital even when she was off duty. Ursula Dwyer states:

> "Also when you came off the wards you couldn't get away from the hospital environment, it was still there. At least, when you get home at night, you can really relax. Over there, you can't. If you went out you had to be back at half eleven...you just couldn't get away from it."

Depending on off-duty, Rita Cooney says that:

> "The days off, work out weird because if you take Sunday off and Monday off, thats your day from last week and next week so you have another ten days to work."

Students work a six day week. A long stretch of duty without days off can exist in all three hospitals (e.g. if a weekend off is requested), and means that students spend long stretches of time working for days off.

Nurses' off-duty means that unless 'home' is near a lot of time is spent in the nurses' home. Like Goffman's (1968) inmates, student nurses can feel that their full time is at the disposal of the institution. Eva Lane indicates this feeling of 'never getting away' as she watches the 'goings-on' in theatre and worries about the time when she must face that experience:

> "And you can see the theatre so clearly here too...I can see it from the bedroom as clear as daylight, just look out the window...I can just see the patient lying there on the table, really, you can see everything up there. You can see them as plain as daylight walking around the room, walking over to a chart, maybe and that kind of thing."

The student going to eat in the hospital canteen (and few facilities exist for cooking in the nurses' homes), is also likely to be confronted with various hospital images and members of the hospital hierarchy.

Students can experience 'never being away from work' even when they move outside the nurses' home. As they spend long stretches working for their one day off per week, students can also spend long periods awaiting their 'turn' for holidays. Angela O'Neill explains:

> "...You are just given your holidays. There is a list goes up and there is no choice. Last year's holidays were the end of February and the beginning of March and this year's holidays are the end of October and the beginning of November. We've had no holiday since last March twelve months until October/November. Its an awful long time with only one day off a week. I've been on night duty three Christmas' in a row. I love the huge hospital but its just those little gripes, they mean a lot to us. We have had to wait nearly eighteen months for our next holiday..."

This feeling of having little time away from work a and of not having a life independent of nursing can arise even for the student who lives out. In St. Robert's, during my observation period, 3rd year students, who were living out, were refused permission by matron to hold a party on a Thursday night, because they were in block and had to be up early and in class at 8 a.m. the next day. The party was to have been held on Thursday because most of the class wished to avail of the rare weekend off to go home. The party was to be held outside the hospital and matron's permission was only

sought because students wished to advertise in the hospital and invite other students and staff to it. Fiona D'Arcy explains what happened:

> "I organised a party with another girl to have in block because we haven't had a block party yet...you know and we wanted to organise our graduation ball and we wanted to get money for this event. And to reduce the price of the tickets we wanted to have a party for it and get the money for it...so I rang up Terenure Rugby Club and I booked a night in block which is next Wednesday ...and I went to Miss Keogh and, of course, we should have gone to matron. And Miss Keogh said 'no' so now we have no party...we had to cancel it. We had it booked and all...She said it would cause two days of interference in the classroom - one the day of the party and then after...too much organisation and then we wouldn't be attentive in the class or whatever and then the following morning we would be falling asleep. But at the same time she said 'I don't give a damn what you do in your spare time, you can do what you like' but then she turned around and told us we couldn't have a party...I was so disgusted with it."

As this account indicates, when student nurses leave the world of late passes and monitoring of free time, they still find that a control above and beyond their work life exists. This control means that they are unable to 'leave work behind' and I suggest that this has an indirect effect on lateral life roles.

A tutor sums up some effects life in the nurses' home can have. She suggests a destruction of lateral life roles. Sarah Kenny, states:

> "You are too busy learning your material and learning for the next test next week to even think how you feel yourself...you probably will lose contact with a lot of your friends that are in other different jobs and in different careers and you are totally nursing. You know - eating, drinking, sleeping, every minute...The classroom from 8.30 - 5.30...our nurses' home is on site. There is a home sister, and the rules and regulations are to be maintained. Even if it was a hostel away from the hospital, but, if you look out the window, you are looking into the ward you are going into. I think the nurses' home is good for the first six or nine months. The students should get out and meet others...They move out with four nurses or five nurses - I don't think that other relationships outside are taken into account..."

Pamela McKeown, another tutor, recounts:

> "They should be normal students and your student years should be fun. But nursing students don't behave like other students..."

Life in the nurses' home, as it transmits the ethos of the hospital training school, helps to ensure that student nurses are not like other

students. Many of the students were not from Dublin and hence living at home was impossible, the majority were glad to be able to live-in for the first month, but, all I talked to felt they were being watched and some related it to the imposition of discipline.

To conclude, the emphasis on residential life, in the early stages of training, on measuring-up in terms of being a suitable kind of person, and getting examinations (see ch. 6) all make the student nurse feel that she can never leave work behind - student nurses find that their 'nursing life' is not so easy to discard. This is related to the experiences described in the foregoing and in chapter 4, i.e. the extent to which hospital authority structures infringe on personal life. Early experiences like 'living-on-the-job', tend to confine nurses' friendship networks as it imposes limitations on their 'role set', and as accounts indicate, the hospital training school continues its attempts to control behaviour and activities even beyond the period of residence in the nurses' home. It seems that, where the hospital training school can influence and control students' behaviour, it does.

COMPLIANCE AND CONFORMITY

Life in the nurses' home sets the scene for students as they realise they must 'measure up', that they are watched and are expected to comply and to conform. It sensitises them to hospital expectations in preparation for the time when they reach the stage at which they can live out. Accounts indicate control of various aspects of behaviour. Even when they take care not to, students can still incur the displeasure of authority. Kay Feary notes that she is already 'in trouble' with she suggests, far-reaching consequences:

> "I don't think I'll get back as a staff nurse here. Seriously...they had a play on, it was a geriatric ward, and we

> were asked by the medical students to put on a little sketch for them. They were having a concert. And the day before we had a geriatrician lecturer in the classroom, and we asked the lecturer about it, because he used to talk to us. And we asked if he knew anything at all we could use, any script or that, because we hadn't a clue...so we made a thing up and there was a few songs with a double meaning to them which we didn't notice, and ours was very mild, really, really mild..We did a skit on a geriatric ward but we rang up the geriatric ward before we did it and we asked them, and he was working down there anyway, so we asked the ward sister if it would be alright and she said, 'no problem', so we cleared it with her, and then there was war. Five of us were called up the next day, she <the matron> said 'it was blasphemous and a black holiday and the only people who laughed at it were your friends...'it was a big effort for us to do it."

Other 'pressures' are experienced by students as they struggle to stay the course and pass examinations (see ch. 6). As suggested in chapter 4, the world of the student nurse is far removed from that of other students. Mary Charlton contrasts the school of nursing with a local college she has attended. The lack of conformity and control is evident in the latter:

> "Everyone's kind of running around and sitting out in the corridors, smoking in the corridors, standing up against walls. If you stood up against the wall here you would be killed. Just to look inside the place you would notice and, like, they come and say it's third level education we have here, but it's not the same..."

The imposition of conformity is most evident in the residential aspects of student life, but these and other accounts suggest that attempts are not simply confined to the nurses' home and the 'living-in' period. The 'living-in' period simply assists students' awareness of the hospital's expectations. Ruth Sweeney, (see p.140) like many others, planned to keep up outside interests but already the 'pressure' of a 'nursing' life is felt in the school and nurses' home. I suggest that this results for students in loss of individuality, as their work, for a time at least, takes over. This period in P.T.S coupled with compulsory residential life in the nurses' home brings home to the student the behaviour, standards, interest and commitment expected of them. It contributes greatly to the imposition of an homogeneity of public performances. For at least six months, and in some cases for longer periods, students are not allowed the responsibility

to organise their own private off-duty life exactly as they would wish. Behaviour and life-style are controlled as: (a) a timetable is imposed in relation to 'coming in' time, (b) restrictions on entertaining friends exist and (c) rules and expected standards relating to desirable conduct are made visible.

As I have indicated, should anyone take these controls casually, sanctions for disobeying or taking them lightly can be very serious. Sarah Kenny, a tutor, indicates what she sees as some of the effects of life in the nurses' home and school of nursing. She suggests that it can lead to lack of personal development:

> "well it's something that I feel...<is>...kind of fostered in nursing and perhaps it comes back to nurses' homes, where you live in an institution, sign in, and it can be an extension of boarding school. You are getting a little more freedom but you still sign in. If there is a party on tonight and you are in the classroom tomorrow, you are not allowed to go but if you were in any other third level education you would have to take your own responsibility and you would do what you wanted to do...you would do it because you wanted to do it and you would come early from the party so you wouldn't be tired. ...in all nurse training schools...you have to go to every lecture...you sit there from 8.30 to 5.30, whether you like it or not and you are not given the choice. Whereas if you were in college you would go to your lectures because you wanted to go, not because you had to go."

I suggest that the foregoing is part of the wider framework which perpetuates the 'institutionalization of innocence' myth (see p. 215) and contributes to the student's feelings of 'pressure' (see p. 192). Also, part of the pressure experienced by students may be as a result of receiving the message that one's personal self, and needs, do not exist for the institution. This mortification and depowerment of self is experienced in other ways, as students find no real room for individuality. Their compliance and conformity is required. Tutors, and some students suggested that a dependence was fostered in nursing, that the particular life-style imposed on nurses through ward (ch.7), school (ch.6) and nurses' home resulted in a failure on the part of nurses to take on responsibility.

A CARING COMMUNITY?

The rigid control and bureaucratic structures of the hospital training school can appear 'uncaring' to the student nurse. This is as a result of a loss of a sense of self and depowerment, sometimes in the face of an apparently harsh, unbending authority structure. It would seem that in difficult situations, students are not helped, rather they are tested further. One student reported, from block, how, when she missed class one day because her father was ill, she was told that she must make up the time in ward work. When she related this story she finished with the words "they don't care about us really". Other students were treated in similar fashion. Martha Higgins, a tutor in St. George's, said: "We expect them to care but nobody cares for them" as she described the insensitive handling of students who failed state examinations. Other tutors present on this occasion concurred (5). Students receive little sympathy or understanding within the hospital for examination failure. Students who fail, feel their disgrace keenly, as they are told 'you've let the hospital, your tutors, your school and your parents down'. They often receive other 'punishments' sometimes in terms of loss of rank, removal from ward or school, etc. (see p. 193). Only those students who happen to be within reach of the principal tutor or matron at the time of results, are thus 'punished'. Students also experience punishments in other ways as they are sent to difficult wards 'on trial' and treated harshly on other occasions. Ursula Dwyer describes her experiences. She is being 'punished' for failure; she is also learning that the service side will determine whether or not she stays in training:

> "But because I had failed some exams in P.T.S. I was told before I went on the ward that I was going to be put on that ward as a test. Before that I was supposed to be sent to Jenner Ward which is a much quieter one. So from the very start I was on edge...You see they wanted to give me a real test to see how I'd stand up to

it. At one stage I was nearly driven away because you know I'd taken so much hassle...Before I went on the ward I was told that I was there for a test, so that immediately put me on edge. And also the particular ward sister, she was the test ... even over small things she'd be standing right behind you coming to check up on you and sort of niggle over little things."

Students, in attempting to deal with personal bereavements, find they also come face-to-face with uncaring attitudes. Mary Charlton describes how the hospital responded to her personal loss:

"Last February my grandad died. He died on a Tuesday and I was working over in Outpatients at the time and the nursing officer called me up and told me he had died. She told me that I would be going home and she said 'I could only allow one day off and did I want to go home on the Tuesday evening for the removal or for the burial on the Thursday? I said it really didn't matter to me, whichever. Because she said it would be up to me, I said then 'I would like to go home for the burial in preference'. She called me back up that evening and she said that matron wasn't going to let me go home at all! She said 'I really don't know what to say, I don't think she has ever done this before and then she said 'maybe if you go up in the morning and just say - tell her your grandad has died, maybe she doesn't know your face and then she will let you go home'. So I went up to her anyhow in the morning and there was just no way...she was just sitting there...'your grandad is dead' she said, 'it's a chapter in the book closed and there is no way you can bring him back to life'. I couldn't believe it! I almost cried but wouldn't give her the satisfaction of it. I was just so sick of her. At that stage I just felt like just going home and not coming back. I really did. She told me that I was off for the weekend and I could go home on the Friday evening. And the house would be full of visitors anyway and I wouldn't be able to talk to my own family. But when I would go home at the weekend it would give me an opportunity to talk to them and she thought I should be there to console them. She was so cold! For someone like that saying she cared for people...I mean being a nurse in that situation caring for people...I just couldn't believe it."

Nuala Ryan, a clinical teacher in St. George's, describes two incidents which seems to epitomise, at best, a lack of an individualized response, at worst, a lack of caring:

"One of my P.T.S.'s, her mother died about six months after she had started and then her father died maybe a year ago and I didn't find out either of those things until about a month ago and I felt really horrible because I had admired that girl and I couldn't understand the change in her... I didn't follow up...I didn't know and there was so much there and to think that I missed out so much with her and that was only one. Another day we had another student on the block and she was sitting down in front of me, and I thought 'my God, do you really never pay attention' to myself, and it was annoying me and at the end I thought I'd get her to stay back and I found she was a week back

> after her mother died and I didn't know and she was in my block. They are big things but I'm sure there are loads of things. Nothing is communicated. And I feel even if they have family problems, I think it is essential that you would know, because I think you would be different in dealing with them or you could understand them better if you saw them upset or whatever. You could bring them through the experience but you're never told."

Despite being in a relatively closed community, aspects of students' personal lives are ignored, as little is allowed to interfere with the student nurses' work role (see ch. 7). Nuala Ryan recognises how students can interpret uncaring attitudes when such events occur:

> "...If I was a student I would expect that the ward sister or tutor knew, so that if they say nothing to me...I would basically presume that...it happened to me so therefore, I'm a student and you should know."

Students learn from all of this that the work of the hospital must always go on. If little understanding and assistance is received when the loss is one's own, what help or understanding can the student, trying to come to terms with death and illness in the hospital, expect to receive. Are they fearful of voicing fears as they hear the words of P.T.S. ringing in their ears "if you're not able for the work?..." This is precisely what Nuala Ryan suggests:

> "I think training is a very anxious time for students but seldom would you have a student coming to you saying they can't fit in...You might see them upset about things certainly, but you will never see them saying that, because, if they say that, they're admitting that they shouldn't be there."

The emphasis on 'measuring up', of being 'on a par at all levels' of 'accomplishing profession' (see pp. 107,118) means that fears can only be admitted to close friends in one's own set, never to those in authority who might be able to offer real support and assistance. I suggest this experience of an 'uncaring community' results in depersonalization and adds further to the mortification process, as aspects of the self are ignored, forgotten or even hidden by the students themselves. Rita Fitzgerald suggests that the school of nursing actually 'damages' students:

> "And I think too that probably we hurt them, and the system, the service side probably hurts them. I don't know who does the most

damage."

Nuala Ryan, describes what she sees as the effects of student nurse training:

> "I feel there is the wrong kind of pressures on the students. What I feel basically about nursing and it upsets me is that a girl comes in and we mould them, and you can see how you're moulding the person, you really do mould them...I know you probably have to have certain discipline, but I really feel they take their initiative from them, I really do. It frightens me and it annoys me. What happens is that they come in enthusiastic, you can see it in P.T.S. I think anyone, who is going through a three year course for anything, will certainly change, but they might have some ideas, I think they're squashed. You're the student so you do the work, you can't have an opinion. I think we should nurture them along both their opinions and try to develop them as people rather than...I think they are really squashed, I really do...I don't think we develop them."

While Sr. Whyte, a ward sister, recognises that more needs to be done for student nurses:

> "We do our best I suppose with the facilities we have granted. I don't think they are neglected to the state where you would say they are neglected...but you would like more to be done for them."

These accounts suggest that the hospital training school may fail to provide a 'secure' environment whereby students can learn and continue to develop confidence in their own abilities.

SUMMARY

THE REALITY OF A VOCATION?

Accounts suggest that residential life assists in imposing a uniformity of existence on student nurses. As a result of living in the nurses' home, which is compulsory, student nurses experience a lack of control and a lack of independence in their lives. Many students likened the experience to their boarding school days. Student nurses are exposed to nursing authority even in their off-duty hours and subject to

surveillance from a number of sources. Many aspects of their behaviour become 'public' and the concern of the hospital; this intensifies students' feelings of being watched and 'on trial'. The link between on and off-duty time, between the personal and the working self, is exemplified as students find their 'coming and going' regulated according to their on-duty time. The surveillance, that is afforded the authorities by residence in the nurses' home, also creates the circumstances whereby students can be corrected and disciplined for undesirable behaviour. It allows the authorities to control, to 'check out' as it were, the student nurses' personal self. Student nurses learn that they have to be 'on a par at all levels', that rules are important and that defaulters will be dealt with most severely. Life in the nurses' home also creates a barrier between the student nurses' past self, the 'outside world' and her new role as a nurse. By moving into the nurses' home and complying with its rules, student nurses find that they lead a segregated existence.

Restrictions on movements and entertaining visitors affect students' lateral life roles. Accounts suggest that social networks are restricted and that student nurses confine themselves to their own occupational group for friendship networks. Some accounts, particularly those of tutors, suggest that, in allowing student nurses limited responsibility for their actions, a dependence is fostered which does not contribute to their personal development. In the course of these experiences students find that compliance and conformity is expected as their personal selves have no place in nursing. This is also reinforced in their experiences of the hospital as an uncaring community. I suggest that the student nurse is depersonalized as a uniformity of existence is imposed.

DISCUSSION

Compulsory residence in the nurses' home under existing arrangements brings students into contact with hospital rules, even during leisure hours. Newby (1975, pp.155-6) suggests:

> "Paternalism... is most effective on the basis of face-to-face contact, that is, deference to traditional authority will be most apparent in those groups and individuals who directly experience the social influences and judgements of traditional elite members.

This indicates the possible outcomes of the residential dimension of nursing life which brings the new initiate into more direct contact with the organization of the hospital. It also facilitates a student's absorption into the hospital culture as it physically removes her from other influences for long periods of time. Dornbusch (1955, p.317) notes the value of 'high scope' by the organization in his discussion of the military academy:

> "This clean break with the past must be achieved in a relatively short period. For two months, therefore, the swab is not allowed to leave the base or to engage in social intercourse with non-cadets. This complete isolation helps to produce a unified group of swabs, rather than a heterogeneous collection of persons of high and low status. Uniforms are issued on the first day, and discussions of wealth and family background are taboo. Although the pay of the cadet is very low, he is not permitted to receive money from home. The role of cadet must supersede other roles the individual has been accustomed to play. There are few clues left which will reveal social status in the outside world."

Such 'high scope' it is suggested (Etzioni, 1964, p. 72), augments 'normative control' by the organization: "because it separates the participants from social groups other than the organization and tends to increase their involvement in it."

In imposing compulsory residential requirements, hospital training schools attempt to create a 'high scope' organization. Goffman (1968) suggests that institutions, requiring a high degree of commitment from their members, may attempt to dispense with past identity by the creation of a 'total institution' and at the same time give 'signposts to correct behaviour' in guidelines, rules, rituals, activities allowed and the

distribution of time and resources (see pp.51-55). Consider Kay Feary's account of 'getting into trouble' because she was involved in a hospital concert (see pp.144-145).

I suggest that from the time training commences, the new initiates are presented with notions of dedication, responsibility and vocation (ch 4). It seems that student nurses accept (at least initially, feeling that it is only until P.T.S. is over), that nursing must be their total existence if they are to 'make the grade'. The role of nurse cannot be left behind once class ends or the shift finishes, not at least for the first six to twenty four months as rules vary with regard to compulsory living-in in the nurses' home. During this living-in period, students are placed in a situation where they must seek late passes, where these passes may be restricted, and generally they find that they must seek permission to do things normally taken for granted. There is also the enforcement of rules associated with group living. I suggest that living and working 'on the job' is a means of bringing home the 'ethos' of the institution to student nurses.

Aspects of a 'Total Institution'

Given student nurses' potential access to the outside world, I wish to suggest that the hospital training school exhibits, in some respects, a surprising degree of comparison with aspects of Goffman's (1968) 'total institution'. Accounts (chapters 4 and 5) suggest a process whereby the self is mortified - this was discussed earlier in this chapter and is also discussed below. The hospital training school would not be identified as a total institution in Goffman's terms, because students are free to move outside the hospital, and as they gain in seniority may spend all their off-duty time beyond the confines of the institution (see p.285). However, in illustrating aspects of a 'total institutional' context, Goffman's (1968) model of the total institution helps to understand and analyse the hospital training school. I wish to argue that without being a total

institution, the hospital training school provides for a 'total institutional' context and in so doing exercises a degree of control and authority over students not seen in other training settings or indeed in settings other than punitive institutions. Such degress of control and authority are not normally associated with educational institutions (6, 7).

A Sense of Self

Goffman (1968) has described the forced deference which may be extracted from new inmates in the form of humiliating verbal responses. For student nurses, deference may be forced as they find themselves required to seek permission to do certain things. Consider students' accounts of permission required for late outings, parties, moving flat etc. described in this chapter and in chapter 4. The problematic nature of status is discussed (see p.110) and related to a loss of personal 'identity equipment'. It is further related to any 'regulation, command or task' which forces the individual to adopt stances not within the 'expressive idiom' of that society (Goffman, 1968, p.30). It is suggested that these occurrences mortify the self. In this study, student nurses were mortified in the ways in which they were controlled and disciplined.

Residential life in the nurses' home affords authorities opportunity not simply to imply ideals of vocation, commitment and dedication but to impose what they consider a suitable life style and demeanour on student nurses. Consider the accounts early in this chapter which indicate that students feel they are allowed little responsibility or room for decision-making even in relation to their off-duty time. Goffman (1968, p. 47) points out that loss of adult self-determination, autonomy and freedom of action produces feelings in the individual that he or she is radically demoted in the age grading system. In the hospital training school, there exists little or limited recognition of, or room for, expression of individual needs or ideas and a demand for unquestioning loyalty.

According to Goffman (1968) this has a number of effects. Firstly, it results in a loss of self-hood as students are no longer seen or responded to as individuals, symbolized in the way they are addressed by the blanket term nurse, or, there may be a 'ban' on the use of first names among students such a practice being considered unprofessional. It is suggested elsewhere that "loss of one's name can be a great curtailment of the self" (Goffman, 1968, p.28). Other factors as described (see chs. 4 and 5) can contribute to this loss of self-hood; e.g. property dispossession, uniformity of possession, uniformity of existence, and loss of privacy with imposed standard of acceptable 'ladylike' behaviour. Goffman (1968, p.280) states:

> "Without something to belong to, we have no stable self, and yet total commitment and attachment to any social unit implies a kind of selflessness. Our sense of being a person can come from being drawn into a wider social unit; our sense of self-hood can arise through the little ways in which we resist the pull. Our status is backed by the solid buildings of the world, while our sense of personal identity often resides in the cracks."

In this statement, Goffman notes the precariousness and importance of a sense of self. I suggest that, in the hospital training school little room for expression or development of a sense of self exists. Student nurses learn, a learning made possible through the total institution, that they can contribute little. All that is required is their conformity and obedience.

Another aspect of loss of a sense of self lies in the way in which the identity of nurse takes over. The new initiate now lives in a nurses' home, she adopts the behaviour and dress of a nurse and to those in authority in the hospital training school she exists only as a nurse. Olesen and Whittaker (1968), in their study, noted how student nurses felt they were responded to by doctors and medical students simply in the stereotyped role of nurse.

Coupled with the encounters described in chapter 4, these experiences

of residential life suggest the imposition of uniformity and at least outward conformity. This can be seen in the way the nurses' home is used to 'judge' character, where infractions are treated seriously and dealt with accordingly. The checking and surveillance of the nurses' home ensures at least an outward conformity. In this way, individuals can experience a loss of individuality as previous definitions of the self may not be sustained. Student nurses commencing training, are informed in different ways of expectations in relation to obeying rules regarding appearance, behaviour and life-style. Implicit in this is that shifts in behaviour of student nurses may be necessary (however strategic), and that the student nurse may be in the position of thinking one way but having to act in another.

Institutionalization

Compulsory residence in the nurses' home has an automatic effect on lateral life roles as students find, due to restrictions, and other factors that a large proportion of time is spent in the hospital. Many students recognised how this operated to 'institutionalize' them as it served to reduce outside contacts and interests. Goffman (1968) suggests that in a total institution, an inmate may feel that all his time is at the disposal of staff with a sense of a state of slavery and self alienation from his work capacity. Degrees of this feature can be seen to be present for the student nurse, as she may be expected to take holidays as it suits the institution, change duty at short notice, or know only a few days in advance what off-duty time she can expect. Student nurses can indeed feel that they are at the disposal of the institution, as reflected in the accounts reproduced in this and the preceding chapter. This institutionalization was heightened for a large number of the students who came from outside Dublin and who were now separated from friends and families. The friendships they formed in the nurses' home became the focus of their lives whilst in training. On the whole it seemed that friendship

networks were built up with nursing groups. The restrictions accompanying life in the nurses' home could be seen to represent attempts to dispense with or at least ignore, lateral life roles; nurses have to be single minded in the pursuit of the nursing goal. The cordoned-off, secluded existence of residents (especially P.T.S. nurses) in the nurses' home, meant that all encounters with non-nurses and especially those involving males, were limited.

Uncertainty

Initial contact with the hospital training school, with its emphasis on caring for the sick and dying, may create uncertainty and anxiety for student nurses embarking on their career, but the pervasiveness of hospital authority may exacerbate their uncertainty and anxiety. With the pervasiveness of authority, uncertainty exists for students as they are never sure when it may strike, hence the desire to escape notice. It was indicated (p. 113), how structures may give rise to 'chronic anxiety' (Goffman, 1968, p.46). Many of the accounts in this chapter indicate an uncertainty on the part of students as they wait to see 'if anything is said'. Authority may or may not strike, but it is ever present and for the student nurse her future career depends on her ability to measure up to hospital requirements and the standards set by those in authority. 'Folk' knowledge and experiences of friends etc. forewarn her that authority can strike, and it can punish severely. Because of her motivation to succeed in the hospital training school, the student nurse is particularly vulnerable to uncertainty and to control in this way.

Powerlessness

Student nurses find that control is exercised not simply in the guidelines and rules described in chapter 4, but as their day-to-day existence is regulated and controlled. As indicated in chapter 2, context is important in socialization. In her discussion of observability as a

provision for control over status occupants, Coser (1961) points out that physical space as well as social space gives man his identity. She states:

> "What we can legitimately hide and what we can legitimately reveal to those with whom we work and with whom we share tasks and team belongingness teaches us much more about the general social dialectic of privacy and secrecy. In every society the right to question must be allowed to be limited by the right to secrecy...the determination of who can hide from whom may be as essential to the workings of a social system as determination of who has power over whom." (Ibid. p.39)

Students' private lives are constantly open to the possibility of invasion and of surveillance by others, but the lives of others are not always open to the same possibility. Also, social mobility and distance between strata are restricted giving superordinates a special basis of distance from and control over subordinates (Goffman, 1968, p.20). Consider the many accounts of the experience of surveillance in this chapter. In Goffman's (1971A) terms, student nurses are mostly engaging in 'front region' behaviour and have restricted opportunity for 'backstage' behaviour whilst in the early stages of training and living in the nurses' home. This surveillance presents the institution with an opportunity to transmit messages. For example, the nurses who were ironing their veils were pursuing an 'institutional value', but the 'surveillance' of their activity resulted in their learning that rules must be obeyed and that the goals only count if they are realized the hospital's way. Such incidents are indicative of students' lack of power. Goffman (1968) further points out that if self-selected expressive behaviour is controlled, resulting in a need to refrain from showing reactions, etc., this is further evidence to the individual of loss of autonomy. Introduction to such a situation may be in the form of 'will-breaking tactics' (Goffman, 1968, p. 85) as individuals learn or are told 'the score' and 'to leave or forever hold their peace'. Consider the accounts of students in chapter 4, this chapter and chapter 6. In these encounters students experience their powerlessness.

As indicated in chapter 4, 'total evaluation' exists in the hospital training school and ways in which this occurs have been illustrated further in this chapter. This exposure to 'total (person) evaluation', can induce a conformity as students 'try to avoid notice' and 'stay out of trouble'. In the United Kingdom Melia (1981) reports the emphasis among students on 'fitting-in' and Maguire (1969) has noted the strong peer dependence in nurse training. Other 'adaptive responses' to such experiences have been suggested and these are now discussed.

Adaptive Responses

A variety of 'adaptive responses' to total institutional experiences have been suggested by Goffman (1968, p. 62) (8). Two of these, 'playing it cool' and 'colonization', appear to apply to nursing. With 'playing it cool', students describe how they try to stay out of trouble by avoiding notice and a majority of those interviewed mentioned this (9). Others exhibited signs of 'colonization' as they reduced tension between past or 'outside' experiences and their present or 'inside' experience by adopting institutional values (10). It is noteworthy that I found little evidence of Goffman's other adaptive response, intransigence, as students initial potential for this response was dispelled by their motivation and 'good fortune' at being accepted for training. Potential troublemakers were sifted out before training started (11). Loss of control and of a sense of self can result in students trying to retain some sense of self in holding back from the acceptance of hospital values. Goffman (1968, p. 279) suggests that the "practice of reserving something of oneself from the clutch of an institution" is apparent in less totalistic institutions. For example, I suggest that in nursing, secondary adjustments might be manifested in identifying more with non-nursing groups (i.e. medical) than with nursing colleagues and could result in bitching or griping against nursing members. It could also result, within the little private space that

exists, in the pursuit of disapproved behaviour e.g. smoking, thus indicating an outward compliance to institutional goals but internal resistance (12, 13). Other stances may include 'stiffness, dignity, coolness', for example, the destriped 3rd year who stated: "I'll just have to keep by head up". According to Goffman (1968, pp. 275-276), such practices indicate to the inmate that they are "beating the system", they help demonstrate "to the practitioner if no one else, that he has some self-hood and personal autonomy beyond the grasp of the organization."

To conclude, I suggest that the message transmitted to the student nurse by way of her residential experience is one of the need for her absolute compliance and conformity to the demands of the hospital training school. This is conveyed in a number of ways (see ch. 4), and to some extent realized through life in the nurses' home. It represents attempts at an all embracing control, as it touches on all facets of student nurses' lives. I suggest that the hospital training school is not content to issue directives to student nurses but rather tries to enforce compliance and conformity. I further suggest that this results in depowerment, depersonalization and uncertainty as students are exposed to a form of total evaluation, in which day-to-day existence, in the nurses' home and beyond, is controlled and regulated. Whatever presentation of self takes place at interview (see ch. 4, p. 94), the new initiate, once in training, must continue to convey institutional behaviour and values. Whatever the strategies adopted at interview, she finds that because of 'total evaluation' (Goffman 1968) commencement of training does not mean that her strategic compliance can cease: The social organization of residential life in the hospital training school ensures that.

The next chapter, presents tutors' and students' accounts of life in the classroom, as it considers the student nurses' experiences in the school of nursing.

FOOTNOTES

1. Newly qualified staff nurses usually need six months experience as a staff nurse to get another post or to move on to other courses.

2. A psychiatric hospital.

3. As Davis and Olesen (1963) suggest, a 'cordoning-off' (see ch. 4, p. 113) is evident.

4. Hanrahan (1968, p. 108) indicates that the tendency among student nurses in her study was to spend off-duty hours in the company of fellow students.

5. Features of this may also be identified in students' accounts of depersonalization (see ch. 7, p. 258).

6. It is for these reasons and to adequately reflect students' experiences that I develop the concept of 'pipeline status' (see ch. 8).

7. Although it should be remembered that the extent of the hospital control may be greatly exaggerated in the student's mind (see ch. 6, p. 215).

8. Goffman (1968, pp. 61-65) suggests five 'standard alignments' or adaptive responses: 1. 'Situational Withdrawal'. 2. 'Intransignence'. 3. 'Colonization'. '4. 'Conversion'. 5. 'Playing it Cool'. "Each represents ways of managing tensions between the home world and the institutional world."

9. This is similar to Melia's (1981) 'fitting-in'.

10. This group is unlikely to increase tension by operating in different types of organizations or approaches to care. They have in these cases become institutionalized. Such nurses are unlikely to be interested in, for example, community care or health education, but adopt the hospital's definition of acute care nursing.

11 Etzioni (1964, p. 69) notes "...the degree to which an organization selects its participants affects its control needs in terms of the amount of resources and effort it must invest to maintain the level of control considered adequate in view of its goal...In general, the more selective organizations are more effective and induce a deeper commitment from their participants than do organizations of lower selectivity."

12. Goffman (1968, p. 276) discusses the practice of 'bitching' as a barrier between inmate and institution.

13. Student nurses' smoking could also be seen in this light, as a reaction to the totality of the institution, a secondary adjustment as the individual tries to maintain some aspect of herself. Somewhere along the line, images of Goffman's (1968) 'release binge fantasy' come to life in a student's account of why she smokes (see appendix V).

CHAPTER 6

THE LIFE OF THE SCHOOL

INTRODUCTION

This chapter focuses on the tutors' and students' experiences of life in the school (1) (2). All student nurses commence their training in the school of nursing with P.T.S. and return to the school at intervals throughout training (3). As indicated (ch. 1), all general nurse training schools are service based and are part of the hospital complex. In some schools, accommodation is shared with other 'units' e.g. with the nurses' home. This serves to present the school as simply another hospital department functioning to the same end as all others (4). In this chapter, I first discuss the tutor's experience of life in the school as a way of considering a key feature of life in the school of nursing for the student nurse (5).

THE TUTOR'S EXPERIENCE: AN ABSENCE OF CONTROL

Tutors find they have little real control over their work. In Irish hospitals, the matron is the head of the training school and all correspondence from the controlling body is directed to the matron in this capacity (see ch. 1). As will be seen in this chapter, it is a source of friction and difficulty, creating frustration and loss of esteem for tutors as it very firmly makes tutors, and education or theory, subservient to the matron and service. The matron, as head of the training school, has a very direct bearing on life in the school for both tutors and students (6). On the need for separate independent budgeting for education, Anne O'Riordan,

a tutor recalls:

> "When we were doing out the brief for the new hospital that was one of the things that we were quite adamant about; that in fact the school should have it's own budget".

Hospitals are resistant to any real changes in nurse education. Martha Higgins, a tutor notes that even in new hospitals: "They didn't start recognising the tutors as head of the school; principal tutors as head of training". Anne O'Riordan points to what happened recently when a large hospital was undergoing re-organisation:

> " But we have a situation then again up on St. Peter's. Now that is the most recent one let's say where they could have taken a stand because of the re-organisation and all the rest of it; now, they have, in fact, at the end of the day accepted the chief nursing administrator as being head of the school....<we said> every school should have it's own director and that director of education just liaises with the director of nursing. Now, that wasn't taken to kindly by the matrons. They resented it a lot, and it was kind of just left aside but, still we kind of said well, fair enough, it has to go down as saying - this is what we want but you might be talking about ten years! But, you have to move somewhere and take a stand on it and I was disappointed that Peter's actually let it go."

Because of the overriding positions of matrons, the principal tutor is likely to find her promotion opportunities closed. She is not head of her training school. Anne O'Riordan says:

> "I think the tutors need to be prepared for promotion as well, and there is only promotion to principal tutor and how often does that arise?"

Hence, tutors often move towards the administrative (service) career structure for real promotion. Tutors receive financial support to undertake the tutors' course through a hospital which so invests, only when necessary. Therefore, if they are to maintain living standards and pension entitlements, aspiring tutors 'wait' for the opportunity to seek such funding - not surprisingly relatively few aspire to a career in teaching.

One tutor describes how she actively sought a career as a tutor and secondment for the course, indicating perhaps how rarely such courses are sought by nurses, as nurses usually wait to be asked, and hospitals wait until they are short of staff before they send anyone on the course. Rita

Fitzgerald explains:

> "...there was an advertisement in the paper for Matthews' for somebody to go on a tutor's course so I said to myself, if I really want to do it I had better get up and go to it! So, I went up to the matron and said that there was an ad. in the paper for Matthews' and I would like to do the tutor's course. She had already organised seconding someone, so I didn't think there was any point in asking her to send me but she said 'Do you want to leave?'...and I said 'Not particularly, I just want to do the tutor's course!'. Five minutes later I was told that I could do it for here...I think there are very few people who ever go and ask to do anything, and I even find even that within our own school."

Maybe Rita Fitzgerald was very fortunate. On the other hand she mentions how none of her clinical teacher colleagues sought to do the tutor's course despite a special one-year tutor's course being offered on a one-off basis to registered clinical teachers. Most tutors I talked to, had been approached by the hospital to train, as gaps arose in staffing. Perhaps many nurses see tutoring as an unenviable position. Alternatively, it could be that bedside ideology is so pervasive that many (especially the more senior) return to the hospital career structure after a number of years. Such aspirations were prevalent amongst tutors I talked to; few were content to remain tutors. Should tutors identify the need to change the nature of student classroom or work experiences, they find it impossible because principal tutors keep a very tight rein on what is happening, this may not be unrelated to the fact that matron has the ultimate power. As she is in the position as head of education and of service matron is necessarily walking a tightrope - service needs are always more immediate. Anne O'Riordan highlights the dilemma:

> "As a tutor you are a specialist in education - that's your primary concern, whereas matron, her primary concern is patient care. I mean education has to come, it's important but it's secondary whereas, our first thing is the student whether we like it or not, and the patient comes through the student."

Service Domination and Education

Tutors, apart from principal tutors, have little say in who gets selected for training. If tutors are present at student selection

interviews they report that they are present simply to rubber-stamp matron's selection and are unlikely to have access to information on candidates until the moment of interview. Once they commence training, schools often collect their own information on students, as their application forms tend to remain in matron's records; the service side maintains responsibility for students. As soon as students commenced training, tutors had to start preparing them for an immediate service role and 1st year state examinations, both of which act as constraints on tutors who have little control over either. Sarah Kenny reports:

> "You have so many things to get through in P.T.S. and you have to get through them - it's a necessity to get through them, and you keep saying that you know we are here to care for the patient. We are saying it, but we are not doing it."

So, this tutor recognises that caring for patients gets left to one side as tutors concentrate on getting through and covering certain parts of the syllabus. In the school of nursing different 'sets' are never combined for formal lectures. Despite the rationalisation this suggests, making more tutoring staff available for small group work, tutorial work or ward teaching, it seems that nursing work (like women's domestic work) cannot be subject to rationalisation (Davidoff 1976). Likewise, as indicated P.T.S. is packed to capacity with presentation of material - putting a heavy burden (as tutors recognise), on students. Yet, six months later, students may come into school for the luxury of a revision block. Both of these factors may be directly related to service needs, as teaching groups are never combined because this would affect ward staffing as larger numbers of workers are removed from ward work. Also, students need to learn to function as safe workers on the wards, and need to have all their anatomy and physiology covered in order to meet end of 1st year state examinations (7).

Tutors also realise that in P.T.S. and block, material may seem unreal for student nurses, as things are different on the ward simply because it

is the 'real world', Sarah Kenny says:

> "I mean in the classroom you tell them to...a, b, c, but in the wards it is a totally different....I think we have probably widened this gap between the school and the ward because, if the student questions on the ward 'Why is this?..., we were told something else!' They're told...'Ah! don't mind them up here - they don't know it!' I am not saying that the school is teaching the wrong way but it needs to be brought across that not every patient is going to experience this."

Tutors recognise that the school may lose its battle for the minds of the students - Pamela McKeown recognises this when she says:

> "I would think probably they forget about the school to a large extent."

It seems that the hospital training school is geared to service and practice; education and theory have little value placed on them and tutors must play their part in this service-orientated structure. They certainly have little opportunity to influence it, and as ward life becomes the main priority tutors may even find themselves excluded from disciplinary action which affects the lives of students. As indicated (ch. 5), on one ward, I observed a third year finalist who had her 3rd year band withdrawn without the knowledge of tutors. When I mentioned it, school staff knew nothing about this incident. They had not been informed or consulted about a decision which was certainly bound to have an effect on this student's reports and future references. Tutors may also disagree with hospital policy towards students. On her disagreement with the way students were sometimes treated on failing examinations, viz the loss of belt, badge, or band, Rita Fitzgerald stated that students should never have been given their rank without the examination result:

> "I really do think that they shouldn't have their belt until they have the level of knowledge...that would allow them to function as a second year nurse, rather than just in terms of months or years or whatever, it's determined that someone should have a blue belt. I think that it should be looked into...their belts should have to do with both, their level of knowledge for the particular period that they are here, what they have actually learned or not learned."

However, it seems that ranks were raised without examination results

because of service needs. Hospitals with an intake of twenty students per year plan staffing on that basis and to send a 2nd year to a ward or department is quite different from sending a 1st or 3rd year. Hence until Nursing Board regulations explicitly stated that students could not proceed to 2nd year block until they had completed and passed preliminary examinations, this anomaly of second years being second years only on the basis of length of stay in hospital, i.e. of service, did not become apparent. Within this service-dominated structure the tutor's status is uncertain. Pamela McKeown discusses her change of status from ward sister to tutor and her now uncertain 'place' on the wards:

> "You make people uncomfortable by appearing on the wards and you have got people either ignoring you completely and not wanting to know you're there or else you have got people going out of their way to trip over you and make you feel comfortable and at home, which I feel is the wrong attitude also, and the result is that I shy now at going to the ward. I only go when I absolutely have to. Because I feel totally out now, because I'm not up to date on what is going on in that ward,....so I feel I am exposed myself, and I do think that one is an embarrassment to the ward sister too."

This tutor's main claim to credibility is her ward experience (8); in her interview and in informal discussions she emphasizes it - perhaps she clutches onto it and displays it so obviously because the status of the tutor is so ambiguous. In so doing she merely echoes the values of the hospital.

Service Domination and Student Assessment (9)

As indicated, tutors are often not consulted on matters affecting students' hospital careers, also, within the hospital training school, tutors' assessment of a student's performance is often secondary to that of the ward sister's. Tutors know that their examinations or assessments of students are less important than the ward sister's assessment of the student's ward work. Ward sisters' assessment which is recorded on the proficiency assessment form (see appendix VIB), permits a student nurse to enter for state examinations. Therefore, senior ward staff (i.e. ward

sisters, not staff nurses), have potentially much more say on who goes forward to state finals and hence more opportunity than tutors to determine the qualified staff of the future (10). Tutors also suggest that ward staff do not realise their own importance in the assessment of students. Anne O'Riordan indicates that ward sisters need to be prepared for this role:

> "What we have to try and get across to the sister involved is the fact that when they are giving them those three assessments, they are giving them the actual right to enter the examination. By virtue of the fact that they have those you can't stop them sitting, you are saying at the end of three years they are proficient from a clinical point of view."

Despite the emphasis given to training hospitals, Rita Fitzgerald notes the lack of training and emphasis on education demanded of trained ward staff, who are responsible in such a hospital-based system of training for much of the teaching at ward level. Tutors note that the hospital ward sisters who assess student nurses' ability to nurse, have little or no educational background or training in assessment; in the hospital, service not education is important. Rita Fitzgerald recalls a visiting nurse educator from Wales who had authority to withhold students from clinical areas if teaching was poor:

> "...Students were not sent there, simply because the level of learning or the interest from the top was not there. I think wasn't that dynamic!"

However, in Irish schools of nursing, educators do not have such authority. Unlike the situation to which she refers (the nurse educator also made decisions about employing individuals), tutors in Ireland have little say regarding hospital appointments. I ask Rita Fitzgerald:

M.T. " Does the tutor ever sit in for appointments; is she even on an interview committee for hospital appointments.

R.F. For staff? No, not to my knowledge - unless for an appointment like mine. But for staff nurses and ward sisters - no, not to my knowledge. I don't in fact know of anywhere they are."

Yet she notes medical personnel and even hospital administrators sit in on

nurse selection committees. Anne O'Riordan suggests that tutors' inability to deal with detrimental effects of training is related to their lack of autonomy in the educational field. Tutors may keep records of students' progress but such records do not form part of any official assessment procedure. Tutors do get an opportunity to see ward sisters' assessment forms but they are usually returned to, and filed in matron's records.

Matron, as the tutors' superordinate, may also question tutors' work and in so doing may control the work of tutors. Should a student not measure up to ward requirements, Anne O'Riordan notes:

> "Matron could ring up and say 'well, you know have I been neglecting the student or what comments have I to make'."

Tutors are constantly reminded that matron controls training. A poor ward assessement is likely to present more problems for a student nurse than examination failure. Tutors have little say in who commences training and with regard to who stays in training. Rita Fitzgerald discusses the problem:

> "I know of a particular student here and she shouldn't be a nurse...she's doing finals soon and I wouldn't like her looking after me. So many people have said it...I think it can be very hard and I know I have recommended that students leave here; they haven't left. I have also recommended people not to leave and they have left, and I find it very difficult to be very strong, and I protest strongly about standards being kept...and I wonder should I really be putting pressure on about her because I know somebody who is equally bad and I know that they are not going to leave because of who they are perhaps, and I feel very sad about that, very sad."

Even in relation to educational issues tutors find that: "If you make a decision you can be and are, overruled all the time" (Rita Fitzgerald). I ask Anne O'Riordan in St. Robert's:

M.T. "Do you think that the school is in a position to say that they strongly recommend this girl to terminate training and it actually will happen?"

A.O'R. "No, it doesn't...I can tell you that it doesn't just happen, you say, it, you get to the stage when you are nearly being assessed for making the decision...We have two at the moment who are about to do their Part 1, they were allowed sit their P.T.S. exam three times, so, therefore, we'll say they are in P.T.S. they must have been in since

> April last year. They failed the P.T.S. exam and they were given another chance, they failed it. They were almost into their first year block with the same amount of studying, you know, there was nothing new added because they had no other block and they barely get passes...they are still here! So, you see you don't really have the authority. Matron has the final decision - there is no doubt about it."

So, tutors can be taken to task when a student fails in the ward setting. Yet, no one listens when tutors point out a student's failure or difficulty with school work, unless this happens to coincide with the ward's assessment. This is further evidence of the hospital's lack of regard for student nurses as learners, for the educational side of nursing and indeed for the tutor herself.

Tutors find that they have no real power with regard to who should remain in training; it is as though they have no real authority attached to their role. They are expected to impart certain information to students so that they may function as safe ward workers and pass state examinations. Within this remit they are not allowed to make any real decisions, nor as will be seen, do they have any real choices in the way they perform the job.

Control by Medicine

Influence and control is exerted by other than the matron. Doctors and other influential figures in society still figure strongly in nursing in Ireland, as they 'suggest' (through 'pull') people for training. Doctors sit on interview panels for senior nursing posts and teach nurses, thus, they are in a position to control and influence events in nursing. Rita Fitzgerald says:

> "....nurses depended on doctors to educate nurses for many years. I have a programme of second year block and it's full of doctor's lectures. We depend on them, alright, it's part of their job. Then, we also have them examining nurses and deciding in fact, whether the nurses should pass or fail, which is crazy. Thank God that is gone now <11> but it also gave the doctors down the years a bit of 'hang in' because in fact they were making decisions without knowing it at all."

On the place of medical practitioners in training Sarah Kenny had this to

say:

> "I can't say I agree with all the doctors' lectures at all, but on the other hand I think we feel we need them to give us confidence, to make us feel part of the team."

This suggests a lack of confidence amongst nurses, as they do not feel 'real' members of the otherwise 'scientific' team. Therefore, doctors are in a position of influence. This arises not only from their influence in the selection of candidates but because they very directly shape the nature and scope of nursing by taking ultimate responsibility for patients on wards (discussed in ch. 7), and by teaching students in the school of nursing. Tutors have mixed feelings regarding this aspect of teaching students, some feeling it added to the status of nursing, others that doctors had no place in the training of nurses.

Medical Domination and the Tutor's Status

Tutors are also only too painfully aware that the medical staff they often fit their own teaching around, have no wish or interest to teach student nurses, and often undertake it gratuitously. Rita Fitzgerald gives an account of her attempts to get six surgical lectures done by one of the younger hospital consultants. She recounted angrily how she had just wasted yet more time trying to see Mr. Smythe to get lectures organised for the incoming second year block. When she first approached his secretary, he was not available. She explained to the secretary writing down exactly what was needed, saying she would come back that afternoon to see him after he had time to consider the details. She returned to his office at the appointed time, was told yes, he was there and had got the message. His secretary then told him Rita was there to see him. She waited and after twenty minutes Rita approached the secretary and asked if he knew she was there - assuming that he must be with someone else. When she went in she found him alone, disinterested and unwilling to commit himself to dates or times and unwilling to allow his house staff to do so either - saying simply: "Well, we'll see if we can organise it between us; my secretary

will fix times". Finding she was, in effect, dismissed, the tutor went to his secretary who was unable to help as she said she never arranged his schedule for him. At this point, Rita decided 'enough was enough' and allocated two lecture periods for times when it was likely he would be available and said she would arrange with the senior registrar to do the other four. Despite being informed of times, the consultant did not say they were unsuitable at any stage, but failed to turn up on both occasions for the lectures with only a few minutes notice in one case and a few hours in the other. A tutor in St. Robert's, Anne O'Riordan notes regarding doctors' lectures: "Sometimes he doesn't turn up and you have to be on the look out to make sure he comes..." It seems that tutors experience a lack of control vis-a-vis medicine in their day-to-day work as nurse educators. Anne O'Riordan had this to day about the undesirability of, and lack of cohesion amongst, different doctors' lectures and in some cases the wastefulness of time spent:

> "I mean I am tired of hearing when we get in a doctor 'he is a specialist in his field' but I could say that I could be a specialist in that field as well if I was allowed to specialise."

This tutor notes how in terms of teaching time, she gets the left-overs and has to fit-in, she describes a timetable for 2nd years:

> "...they then have chemistry and they work in the laboratory, then we have Mr. Walshe and Mr. Somebody else, now you <the tutor> fit in. You might have three hours...and in fact you cram the time..."

Anne O'Riordan says that such 'forced deference' to doctors and fitting-in does have a detrimental effect on tutors' morale. She locates the problem as lying in nursing s embryonic stage of development in Ireland. Anne Kennedy points out how her work is devalued as the only time for which credit is given, is time spent with students, teaching. As in the hospital, 'doing' is what is important. No allowance is made for, or regard given to, time spent preparing, planning etc. Tutors also find that they are unable to plan their own work and timetables.

Students pick up messages as doctors teach them (discussed later in this chapter), subjects come to be identified as having more priority and higher status if taught by a doctor. Higher status in nursing tends also to be linked to the status of medical specialities, and tutors feel devalued as the timetable they are filling, not planning, is not designed as they might wish but is built around the availability of doctors. Tutors complain that many doctors come to teach nurses with little understanding of nursing practice. They talk, as if to medical students or qualified medical staff. Nurse tutors are criticised for being out of touch, for not being experts in the field of practice, yet, lack of organization in the school precludes this. Like the primary school teacher, tutors must teach all subjects and cover all areas. Like many ward-based nurses they remain 'generalists' (Alexander, 1982). The doctor is seen as the authority figure in training and nursing, and medicine and doctors become models for student nurses rather than nurses and nursing. On the school's lack of influence and the ward's influence Anne O'Riordan says:

> "Let's face it, they are only in the classroom for a set number of weeks in three years, so, I mean it's not a lot of time to teach them that, so I think what they see has more influence than what they hear. If I go to the wards with students I am more inclined to maybe do something like a bed bath, but if they could only find out..it is not always the big things. They consider a dressing a big thing, or they consider doing medicines a big thing but that those other things are equally big."

Tutors recognise how students identify a ranking of work and attach more status to that most closely associated with medicine - real' nursing gets left to one side.

The Problem of 'Pull'

Tutors, in one of the study hospitals, emphasized an outside influence on selection for training; the problem of 'pull', through having influential connections in the hospital or society, this is now discussed. Pamela McKeown discusses educational entry requirements for nursing and indicates that she has come up against the problem of 'pull', she states:

"I don't think the academic standard isn't high enough. I think what happens is that we accept people below the academic standard that we have set..I think there is a lot of politics involved in nursing nowadays..."

She continues:

"I had the experience as a ward sister, of a student coming to the ward, and I put her looking after a patient and I observed her and I saw her looking out of the window - the patient was a very sick patient who needed the nurses eyes on him, and she seemed to be twiddling her thumbs and didn't seem very interested. I watched for a long time and eventually I called her and I said 'What's wrong with you? Obviously, you haven't got your mind on your job: can I help you? and she said 'no', and I said 'it is obvious to me that you are not interested! Is it because you're sick? or is there something on your mind? and she said 'no' to all this and I said then...you're not interested and we can't have you here and that's the way it is!' and she stamped her feet at me and told me I had no business to tell her she wasn't interested, whereupon I went down to the matron and I said 'Look, there is a nurse up there (I had never done this before) she is a 3rd year nurse and she is totally disinterested.' And she said 'well, you know who she is' and I said 'I don't but it doesn't make any difference to me - she is not interested in nursing and she said 'well we can't do anything about her now she is in' and she was there three years on."

Rita Fitzgerald says:

"We are under big pressure...and more and more we are told, when we find that when we run into a problem with particular students that somebody has her here and...just recently, one of the girls who failed <u>en masse</u> she failed all her papers; she didn't pass anything and I know that she is a particularly bad student and one of the consultants here has been to and fro and to and fro all year about her so, there is great pressure. And like...so they can be nurses...I mean why isn't that girl if she is so interested, why isn't she in medicine?"

Rita Fitzgerald suggests that the problem is linked to nurses being female.

On the control of nursing by doctors, she says:

"Men can put pressure upon us so easily, and I think also this old thing when nurses were subservient to doctors and we still carry this business about the doctors who can decide if someone wants to be a nurse..."

She says the solution

"...is that we should stick with whatever we want, like if we say that you should have pass maths and C's at whatever level - a 'C' in English, or even in fact if they are going to say an honours paper in English, I think we should stick with it. But, we find that we do not stick with it at all. There is no way in which we stick with it."

This tutor's statement sums up the situation and her own frustration. She identifies pressure that she sees is on nursing from medicine and also sees her own lack of influence in resolving it. It highlights the problem of nursing as a female occupation and as an occupation subservient to medicine (Ashley, 1976; Garmanikow, 1978, Ehrenreich and English, 1976). Tutors' accounts indicate that nurse education is, albeit indirectly, controlled by medicine.

THE TUTOR IN THE CLASSROOM

Tutors find that within the classroom, as they strive to get through 'all the material' they very often have little choice with regard to the subjects they teach. They are dictated to by a syllabus, which Anne O'Riordan, described as the subject of 'curriculum explosion not curriculum development'. Anne Kennedy states 'we don't have curriculum planning, we just have a syllabus'. Tutors are also dictated to by the hospital who need safe, competent workers appropriate to students' stage of training. Sarah Kenny notes the difficulty of simply trying to 'cover the syllabus':

> "It's a lecture hour after hour after hour. I think sometimes that again we get this list that we have to do all these things and that the easiest way is to prepare a lecture and go in and give it and the studentds are happy that you are giving it to them whereas if you make them work out the situation it does take longer."

Hence, for tutors the mode of transmission tends towards the formal lecture as they find themselves required to present the 'facts' as quickly as possible.

Hierarchy in the Classroom

Tutors, as indicated often find that they have to plan their teaching around the availability of specialist teachers (most especially, medical staff). Also, other considerations (ward work, registration part one examinations) mean that in school, tutors have to give priority to certain

subjects. Sarah Kenny indicates how she emphasizes some knowledge whilst she feels she should be doing otherwise; she says:

> "I am in personal conflict because I think that before a student can fully function...<they need> some basic knowledge ...they need to know the normal and then to relate it to the abnormal and I think that more emphasis, a positive emphasis, should be placed on that through our training - start at the norm and then let students work it out when the abnormal comes in. But, that isn't done, because it is quicker for us to give signs and symptoms and not let the students work it out and I think that is where the basic conflict comes in."

And so students do not learn about health but about disease. Atkinson (1979) notes how medical school teaching reproduces particular versions of medical practice and Armstrong (1977) indicates how structural aspects of medical education transmits definitions of disease to students.

'Checklisting'

In some hospitals tutors are in the position of having to sign for each period spent in class, stating date, time and topic covered, with the signature of the tutor (see appendix V1D). The principal tutor in one such hospital explained that the 'checklisting system' (12):

> "...had to be done because time was being wasted. Some people just weren't getting the job done."

Regarding the 'checklist', Rita Fitzgerald says:

> "We have to sign it and we have come to the stage now where we put a date on it as well..."

On the way in which her work is structured by the 'checklist', Pamela McKeown had this to say:

> "Personally, we were given a structure...to account for our hours and so on, and I felt very annoyed but now that I see what I attempted to do without those guidelines, I see where there were gaps in the information I gave the students..and sometimes I think maybe I didn't prepare them for what I am supposed to be preparing them for."

She discusses some of the problems this checklist presented for her and expressed less strong views at this stage than when the issue had come up in informal discussion; earlier she had more or less suggested that it was a plot to control her. On the other hand some four months had elapsed

between the informal discussion and recorded interview, so perhaps it illustrates how individuals conform to, and justify, the institution's requirements. Yet she says:

> "I'm very confined to what I have to get across in the time they make available to me and I have to tick off literally the things on the agenda, everything has to be covered, and there is holy murder if it's not covered."

On the 'checklist' Rita Fitzgerald says:

> "It was really drawn up by all of us, and it is generally what we do....I feel really that there is pressure on me to go in and do something that is on this list, and that is dreadful, because sometimes when you go into class and students raise a topic which you and I hate to say 'I'm sorry..' and I feel very bad about saying I'm sorry, 'I haven't time to do anything on it'."

She suggests that this 'checklisting' can narrow and restrict a tutor's focus, and notes how such a system can be abused to the detriment of students and teaching:

> "I think some tutors would probably see that what's on that agenda, once that's covered, that they need not open their mouth about other things."

This 'checklisting' has the effect of further limiting initiative and controlling tutors who cannot afford to be diverted by students' questions when lecturing and it adds to the formality of the already formal teaching methods. Rita Fitzgerald suggests that with such a system, tutors are almost divested of individual responsibility and this can give rise to a form of 'tunnel delivery' of facts with communication entirely one way, with no reference to the student's current state of knowledge. Most hospitals operate an accounting system similar to the one described, as tutors complete records at the end of each block. However, as Rita Fitzgerald pointed out - it's probably the interpretation of such a system that's at fault. Pamela McKeown also questions the source of such rigid structuring in nurse education, she says:

> "...it is not clear whether that control is determined by An Bord Altranais, or it's the way people actually interpret that kind of thing."

I suggest that such rigid structuring arises because students are service employees, and is reflective of nursing's ambiguous status.

'Generalists'

Anne Kennedy contrasts her position as a tutor with that of ward sister, she says life in the school is very different:

> "...Because after all you have been involved, totally responsible and you come in and you are sharing w th everybody, that is an awful change, and you are no longer in charge the same way. That is a big change...but..I have done an awful lot and got away with it."

Practices vary in schools of nursing. Anne O'Riordan felt her situation would have been helped by having her own groups of students and being 'their tutor' for the duration of their training but she did not have the freedom to do this.

> "We don't take charge of a group, we all go into each group now and again; it would be better if we had a tutor taking charge of a group of students...but you need that, you must be given that opportunity as well I think to be responsible for organising their class...Now we don't do that."

So, tutors find they have little responsibility for, or control over their work. Specialists are brought into the school of nursing to teach some subjects; tutors are kept 'generalists' in an era and an atmosphere of specialization. Pamela McKeown describes and contrasts her current position as a tutor with that of ward sister, she suggests the role of 'generalist' is forced on her:

> "I have gone back to the status of G.P. now, having been a consultant in my own field and I was there for 12 years and there was nothing I didn't know about that particular field, now I'm trying to teach every blessed thing under the sun and it's just not possible...I find it impossible to keep up to date on things I'm supposed to teach. I am expected to teach everything and there is no way that I know enough to teach everything."

So she feels at a loss and out of date, and in her relatively new role as tutor (after three years), she feels ill equipped to teach nursing as it relates to medicine and surgery. Nurse tutors are also kept 'generalists' by their nursing colleagues. For example, having taught paediatrics in one block, when the same lectures are required some six months later, they

may find they are no longer teaching the subject and they and others must prepare new topics. I overheard one older tutor advising a newly qualified tutor to prepare lectures in various topics if she had any spare time saying "it's as well to be prepared, my dear, you could be asked to do anything here." . This also presents difficulties as tutors are assumed to 'know everything . Despite being 'generalists', tutors, because of the variety of controls and restrictions on their work and the presence of other specialists, are not afforded the opportunity to integrate subjects for students - existing arrangements appear to prevent this. Blocks are designated depending on stage of training, namely, preliminary training school; first year revision block; medical block; surgical block, final revision block. The composition of blocks or timetables is not discussed on a regular basis, and the same programmes are presented to students year after year. In the school of nursing, tutors find that there is little room for ideas or individuality.

A Lack of Integration

Within the hospital training school, service and education remain separate. Clinical teachers are expected to bridge the gap between learner and worker, and between ward and school, yet they find that they are on the fringe of both areas, being neither of the ward or school. They are not expected to be in the school between 8.00 a.m. and 5.00 p.m. because they are supposed to be on the wards, yet when allocated teaching time in the school, they feel they are really meant to be on the wards. In one hospital they go to school of nursing staff meetings on only every second occasion and have no formal meetings to discuss items with each other. One of the hospitals had no clinical teachers. Nuala Ryan, a clinical teacher suggests:

> "To me, I feel if we were free to come over <to the school> it would be better. It would be better if we had more resource to what is happening over here. I do feel it would be a lot more beneficial to us. So therefore, you would have the continuity

> from the schools to the wards and maybe to the students because I think they can feel and sense obviously that we're not over here.."

In the classroom, divisions and boundaries exist between subjects because tutors do not usually relate to other tutors or non-nursing lecturers to work out and integrate subjects. So, the hospital chaplain talks about the care of the dying and the tutor tells nurses to read it up in their nursing books The relevance of much of non-nurse teaching of students is in question, simply because programmes are not re-assessed, and tutors when using outside lecturers, for various reasons, do not discuss content in detail or attempt to relate it to their own teaching. The difficulty of integration is illustrated by the account Rita Fitzgerald gives of her encounter with Mr. Smythe (see p. 171). She also explains the divisions that exist between tutors and visiting or outside lecturers and instructors, the following account illustrates the point:

> "...in third year block we have a practical programme arranged, during which the students go from the school for a whole day and they visit all sorts of areas in the hospital like the ECG and special tests and stuff l ke that, and over and over again the students come back and say...that the small areas which they're in are not big enough number one, and the people talk to them about the machines, and they don't really see the relevance of what's there for them, and I wonder what's the point at all unless we know what exactly is to happen?...we are not in fact saying anything to people who are taking them for these periods, you know to say...would you ever say, this and this and this, or talk to them about this. In other words so we have a mechanic over there working a machine and he is into all the thing about the machine, but what do nurses need to know about the mechanics of the thing?

She states what she would like students to experience:

> "...if they went over to the ECG department that they would be told about the different types of ECGs that are done, like the ones on resting and the exercise ones and whatever, I would hope they would explain to them about the graph paper, you know and what the different things mean on it, or something like that. Rather than this machine is..."

So she complains that one is never sure as a tutor what non-tutors have covered, unless one sits-in, and/or meets and discusses content of sessions with visitors. This does not happen for a number of reasons. Firstly,

given the hierarchical arrangements in the school of nursing, tutors may not have arranged the timetable. Secondly, time is not allocated for such liaising. Thirdly, in the case of some doctors and some visiting lecturers this type of questioning is not possible, either because of hierarchical arrangements or lack of knowledge of the subject.

LACK OF INFLUENCE AND THE DIFFICULTY OF CHANGE

Tutors, while hoping to convey a sense of responsibility to students, find that they themselves are controlled within the system. I suggest this is clear from the preceding accounts. Tutors can also be subject to more open checks and controls as they are made to feel personally at fault for the failure of students - students they may have suggested should terminate training! This taking of blame for student failures was most marked among the more senior tutors and appeared to stem from their position of answering to matron and/or boards of management regarding failures. Other types of controls appear. For example, I overheard a principal tutor correcting a student for appearance saying: "I would have thought your tutor would have corrected you by now." Thus, tutors are drawn into the maintenance of existing standards. They may lose face to students - students become aware that tutors, must also answer to a higher authority. Illustrative of teaching staff's lack of control is their inability to bring about change. On the difficulty of introducing change Nuala Ryan, a clinical teacher, says:

> "I feel its difficult for us to bring in change..if more were expected of us then more would be given because I know in certain things, certain ideas you'd have..normally I would go to the older clinical teachers and I would say whatever and they would say well, you can bring it up but we have brought up certain things, and it's like beating your head off a wall, there's no point because you won t change them or whatever...and I think that kind of thing gives you a certain amount of apathy.

M.T. What sort of things might you want to change or might the other

clinical teachers want to change?

N.R. Well, first of all, just taking the basic thing like say the example we have for the bed-bath, we have a certain routine that you do, it's not practical and I know in my heart that the bulk of the students don't do it and I wouldn't expect them to but at the same time, it is within the practical book so therefore we have to go by it - now if you bring that up..."

Thus, she fails to attempt change and an opportunity to bring theory and practice closer together is lost. From accounts of staff meetings it was evident that tutors find it equally difficult to change the existing order in schools of nursing.

Rita Fitzgerald describes an incident which illustrates how difficult change is; it reflects the devaluation of education compared to practice:

"When I used to work in Mary's and I could apply it to here too... a lot of pressure was put on us about things that matron wanted from us, like doing shift work and stuff like that. Now, for the first time in her life she had three tutors and they were very badly needed to organise the school, because there was absolutely no organisation in that school when I was there.. The very first time that she <the matron> had some hope of having a school somewhat organised, she immediately wanted to split us up, you know and be on shift, and do rounds in the evening, and you could walk on the wards and keep the students on their toes. So you could be a 'jack of all trades', you could be the assistant matron, or the allocation officer, or the matron, or the tutor, or the home sister, or God knows what!... <they were> desperately lacking in teaching staff, and here she has the first opportunity,... So, we discussed it, and said no; she couldn't accept it, and she really threw us out. We were really castigated for not falling in line."

These tutors managed to resist the situation described above but not without being made to feel they were doing the wrong thing and had aroused disapproval. It would seem that the more likely tutors are to take their p ace as educators, the more likely they are to arouse the disapproval of the matron, who is after all their 'boss' and the head of their training school. Very few are allowed to feel secure in the hospital; tutors are no exception. They must also 'fit-in' and maintain a surveillance of students and keep them on their toes. They also are kept on their toes as results are appraised. Pamela McKeown, who had been a tutor for four years and before that a ward sister for twelve, recounted what happened when she

visited the school of nursing during her course and was asked by the principal tutor if she was enjoying her course:

> "and I said, I've got lots of new ideas and I was told, you can keep your new ideas and come back and all you'll have to do is teach."

Rita Fitzgerald describes the effect of 'checklisting' and other controls on her:

> "I would find that using that, apart from other things I think general schools tend to drive a little bit of motivation out of you. That's what I find, I mean the motivation I had after the tutor's course, and within two years after that I would find I haven't got the same."

She concluded stating: "I sort of feel boxed into this place at the moment." Tutors find their motivation and initiative stifled as they are not allowed control over their work or to introduce change where necessary.

SUMMARY

To summarize, because of the way schools are organized, an emphasis on formal teaching is forced on tutors. The observed layout of all three schools suggest this emphasis (see appendix IIIA). Scrutiny of timetables, classroom observation and tutors and students' accounts, suggest that the teaching method most used is lecturing. There is little emphasis on self directed learning, most especially in the early stages of training. Tutors themselves find they have little freedom, and this in turn must be experienced by the student nurse. Tutors are not responsible for planning a day in block or a week in block, they do not have any real control over their work. It was apparent from interviews and discussions that tutors might like to do things differently; some might like to start a subject in one place and follow it through in a particular way, or set reading, which would mean that they would not want to be in class everyday talking about a subject. But on the whole the tutor who believes in self-directed learning, or an hour's study period after a lecture to consolidate

material, will find herself defeated by the system as she hurries to get through the syllabus. Because of the full use of all timetable space, even if questions are raised and discussion started, tutors always had to finish when their time was up. Also, as indicated above, they might even avoid being led in other directions because of the pressure to get through so much information - the emphasis was not on getting knowledge across but on getting through it and presenting it.

In line with the hierarchical relationship in the hospital, tutors recognise that students come to see and value work associated with different hierarchical groups, in a hierarchical fashion. Gaps could occasionally be seen in the timetable as confirmation of doctors' availability for lectures was awaited or the lecture cancelled, and tutors fitted their teaching around these. Also, nursing was not seen as something that could be taught entirely by nurses, even those nurses specially qualified to teach. The expert, the doctor, had to be brought in to supplement the work of nurse tutors. Nurses as tutors were not presented as specialists in any field and this contributed to tutors' poor self-image and frustration, and to the 'importance' students attached to subjects taught by tutors. The hospital hierarchy predominates in the school of nursing. Tutors find themselves working within a system which has no desire to change and to which they can bring little to bear. They must simply fit into the existing order and fill gaps in the timetable as requested.

LIFE IN THE SCHOOL - THE STUDENT NURSE

The background to life in the school for the student nurse has been described in chapters 4 and 5, and in the preceding accounts of tutors' experiences. All students commence their hospital training school 'career'

in the school of nursing as they are in Preliminary Training School (P.T.S.) for the first six to nine weeks.

Allocation of Time

As will be seen, life in the school is controlled for student and tutor alike. Neither tutor or student experience flexibility, as schools of nursing operate a forty hour week. When allocated to block, students are expected to be in school from 8.00/8.30 a.m. to 4.30/5.00 p.m. with half an hour allocated for lunch. This means that the rigidity of the eight hour shift and short meal breaks is carried over from the hospital to the school. Whatever justification may exist for this in the hospital, none exists in the school where longer breaks may improve concentration and the effectiveness of learning. However, students have no wish to see their day further lengthened, and as any extra meal break time would automatically be tagged on to the end of the day as extra time to be spent in the classroom (to complete their forty hour week), tutors may rightfully say that the system suits the students. Like nurses on the ward, sometimes the students in class only know on a week-to-week basis when they are to go to lunch. Regular, planned, unhurried mealtimes are not a feature of life on the wards and hence, it appears, cannot be a feature of life in the school. It also keeps to the forefront of the student's mind, that, even while in school, she is a paid service employee of the hospital and has little control over her routine. The rigidity and structure of the hospital can also be seen in the organization of the school timetable as it is filled to capacity with lecture after lecture, hour after hour (see appendix VIE). Mary Kelly notes:

> "We have lectures pretty well one after the other. We start at half eight and we'd normally start with anatomy until about half nine or a quarter to ten, we're all pretty well falling asleep at that stage and she sends us out for a run and back in again then and we maybe do microbiology or hygiene or something like that."

As indicated, these sessions are allocated to formal teaching and are broken into hourly or two hourly periods.

Hierarchical Control and Authority

Students do not wear uniforms in school, however, tutors do, and hence something of the hospital is carried over to the school. The hierarchical structures are also carried over from the hospital environment. Hence the exchanges in the classroom are more hierarchical than other pupil-teacher relationships. There is a dual authority role, first as teacher and secondly as a senior nurse. Authority is experienced within the school, attendance at all lectures is compulsory; students must attend between 8.30 a.m. and 5 p.m. whether teaching is timetabled or not (as indicated by tutors, it invariably is); a 'roll call' is taken and students who are late are faced with the threat of being sent to the wards for the day, (matron's office would then know of the lateness). If students fail to attend the matter is reported to matron's office. Service again predominates as the odd day missed from the classroom may be made up not in the classroom but in ward work (see ch. 5). Students were very conscious of the hierarchy. One student remarked of the principal tutor that "You shook in your boots when you saw her". Formality is maintained in the classroom, students are called nurse by tutors while in the classroom, and methods of teaching are formal (13). Most students found Preliminary Training School difficult. A 3rd year, Angela O'Connor stated:

> "They could start by being a little bit nicer to you when you come in...jeepers, they re.. they're out to frighten you...telling you if you didn't want to do nursing you shouldn't be here and get out now...and if you couldn't cope with it you shouldn't be here and get out now, they really terrify you, you know. I know I was terrified and talking about it now so many of the girls used to go...into the bathroom and that and cry..ring home every night...We talk about it after P.T.S., but we didn't know each other well enough at the time, although each girl was going through the same thing you were going through."

Patricia O'Brien, a 1st year student in another hospital states:

> "I felt that well if I failed that I am going to be out on my ear..I wanted to be a nurse and I wasn t going to let them get me out over a few exams and I was going to study to get a pass and then I felt if I failed I would have to go home and what would my

parents think and I felt they deserved more than that."

As indicated in chapter 4, the nursing authority structure in some cases is very clearly spelt out in introductory handbooks. Once in training students are all the time learning who controls and who has authority.

Discipline and Control

As indicated at the beginning of this chapter, tutors experience a powerlessness and a lack of control over their work in the hospital training school. This lack of control is passed onto and experienced by students. A lack of student involvement in the teaching process is also evident from the way students are treated in class. Peter Finnegan, a post-registration student, notes that this is true of medical staff as well as tutors:

P.F. "Some of the medical staff come to give you lectures and talk about treating people as individuals, whereas in class they see us as a blanket of students, a mass of nameless faces, they don't see people as individuals, or treat you as such.

M.T. Do you think the tutors see the nurses as individuals?

P.F. Thats very questionable, because they don't like their viewpoints challenged...Their idea of training would be that they give you the information or they give you the moulding, and you mou d yourself off the general training of the hospital and the general work pattern of that hospital. You have to adjust to suit the hospital."

The message he gets from such control is clear; the students have low status and know very little. They are there to be moulded into the form the hospital wants. One sees this also from the way students are expected to sit and take notes in class without complaint; I ask Maire Cummins:

M.T. "If you sat there and didn't take notes, do you think you would be reprimanded?

M.C. Yes, absolutely. I'm inclined to doodle and not take things down and Kate has given me the nudge and said they're looking at you, its not very often now maybe something I've taken before and the glasses come off and they are looking down at me, what are you doing sort of thing - I think people are afraid to say anything..what infuriates me then is that you go home and open up your textbook and its all there, so why can't she say, these notes are from such and such."

Control is exercised in other ways by principal tutors as they go through the motions of 'listening' to student suggestions or grievances. Miss Burns, a tutor reported to me that students had requested a meeting; she explained that this happened periodically as different groups of students moved through the system.

> "It'll be the same thing all over again...classroom hours...meal breaks...etc. just what I've been through with those before them...but of course they've gone now and a new crowd want a meeting and it'll be the same things all over again..."

Implicit in what she had to say was that nothing would change as a result of the meeting and little did. Students' experiences imply to them that they have little to give to the hospital situation and certainly have no power to change anything. Maria Fox gives an account of a student-matron meeting.

> "Everything we ever suggested changing, there was always a reason and therefore it couldn't be changed. One of my friends heard that her cousin, who is a student and she is very outspoken about her student rights and what should be done and she has been told 'don't bother coming back to us for a job - we are not interested in your sort.' Now I don't know if that is totally true but this is what I was told. The student-matron meetings are a farce because everybody is afraid to say anything, you know anything you want changed has been asked for before and nothing has been done."

Students also learn that it does not do to draw attention to oneself and that it is better to keep a low profile. Implicit in this is that one may be 'under surveillance'. Control is further extended to 'surveillance' by colleagues (chapter 5 illustrates other aspects of surveillance). Students in some schools found that they sometimes must become the 'eyes and ears' of tutors, as tutors delegate this task to class representatives. Maire Cummins reports on life in the classroom:

M.C. "It's very structured, very much restricted. Even at the last block, people are coming in at five and ten past eight, from what I believe, the class representative was asked to tell who was coming late and who wasn t coming late, what a thing to do among colleagues when you're meant to show a loyalty to one another and everything.

M.T. Are you checked in, in the mornings?

M.C. I haven't noticed it this block, but at that last block, it went into her every Friday who was late or whatever."

In another incident in another school I witnessed the elected class representative being stripped of her 'office' by the principal tutor because she was late for class. Even elected class representation is controlled by those in authority. Student nurses do not have access to power or even 'rights' in the hospital training school. They experience a strict discipline and control, this is discussed further in relation to a sense of responsibility (see p. 190).

'Pace-Setting'

Control, and hierarchical arrangements are also experienced in other ways as the beginning of a block is often seen by senior tutors as a time 'to set the pace, to be tough and to generally give students something to think about.' Aspects of this are discussed (ch. 4, p. 100); Mary Charlton explains:

> "Even when a class starts, when they start teaching us I don't mind, I think it's just this thing that when they come in and start telling us we're no good, that we never do this and never do that and we're not doing enough that we're just going to have to do more or we'll never get our exams, this kind of thing, that kind of negative attitude all the time, they all do it, there is probably only one of them who ever comes into it and says, don't worry about it if you don't know it, I know that you have been on the wards and you probably haven't seen it, but the rest of them say, it was your duty while you were on the wards to make sure that you knew this coming into block, but when they actually start teaching you something I don't ever mind, its just this kind of thing ten minutes before class they would give out to us and Miss Keogh never fails, there's often times that she comes in and we don't have a class at all, it just total giving out. I think its just an attitude that they come in with, the negative attitude..."

Patricia O'Brien describes what happened the first day of her revision block:

P.O'B "When we came into block our lecturer...our tutor told us...two thirds of you are going to fail.

M.T. Have two thirds ever failed?

P.O'B Usually nobody...maybe one and this was last Monday morning at

8.00 and it put us all off for the week...you know you don't know anything...no hope for you and there is no point studying...We have been eating the books since! So the pressure is on for the next couple of weeks to get the exams."

Peter Finnegan, gives some idea of his first day in 2nd year block; he also indicates a 'pace-setting encounter':

P.F. "Well it didn't really concern me because I was starting off...it was to do with things that happened last year in the class, things that didn't really concern me, yet there was a dig in it for post grads. Some post grad...was sitting in on sociology, she was seconded from psychiatry and she had done all this part of sociology before and she thought it didn't really concern her. She sat down and started to write something else, I'm not sure what it was but the teacher called her and reported her and of course there was problems.

M.T. So you were told this on the first day, what else were you told that you didn't think concerned you?

P.F. About nurses being inefficient on night duty, and I think it did apply to some of the nurses in class, something to do with a ward sister who had reported them, it didn't really concern me so I wasn't really that interested."

Pace-setting is carried over not only from block to block (as tutors try to ensure that they do not have the same prob ems this time as they had last time), but also from ward to hospital - the latter is a feature of the 'total institution' as boundaries to authority jurisdiction do not exist (Goffman 1968). These 'pace-setting' encounters also deny students 'a sense of responsibility' and they react by complaining that they are treated like 'bold children'.

A Sense of Responsibility'

Third year students in all three hospitals reported that, as they gained in seniority they were treated a little better by authority. But students also got upset and angry at the contradictions inherent in approaches to them. They were growing up, but they were still children in the eyes of the school. Maire Cummins says:

"They treat you like a bold school child and I don't know how the attitude got in or why they adopted that attitude. They don't go to get much response out of the class - you could just sit there for the hour and just write notes after notes after notes."

Being treated like children figured largely in students' accounts of life

in the hospital training school (see chs. 4 and 5). Paula Jennings, a first year says:

> "They treat you like kids, they come and they talk at you...it's worse than being in school. They think that you are not capable of doing anything!...I mean they are not all the same but they just talk at you...rather at...than with!"

and she continues:

> "Down in the classroom they give out to us for being very quiet...but you know the way it is with the tutors. If you say anything that you are not supposed to...you just sit and listen and don't move. You would get a cramp from sitting still all the time! It seems wrong that on the wards you are given so much responsibility and then when you come into the classroom you are treated worse than in school."

Both accounts indicate how such attitudes and experiences affect classroom encounters. These experiences serve to remind students how insignificant they really are and arouse comment simply because of the effect it must have on their self-esteem. It could be seen as a deliberate strategy of control as it creates self-doubts and anxieties. Once they have been out of P.T.S. and on to the wards, students feel more the sense of a lack of responsibility that comes across to them in the school. Maria Fox says:

> "I think work is a complete contradiction of nursing because you are on the wards, you have to be an adult and you have to do a responsible adult's job and when you are in block you are treated like a child. It's not much this year but last year even if you just turn round to the person beside you - 'stop talking' - thats what you say to children.. It's silly...it's just so intensive. It's back to school but it's back to kindergarten school in so far as you have no choice!"

Deirdre Kane recounts the difference it makes when a tutor relaxes discipline:

> "We had one tutor and she was a class tutor all the way up and she was briliant. She was willing to sit down at the end of the class and just chat about everything...not just nursing or the hospital...just about life in general which was great!"

Control and discipline is felt most acutely by students in the school of nursing. Sarah Kenny, a tutor, recognises this control, she says:

> "We are taking the responsibility and we stand on guard to make sure they are all in."

On control and discipline in relation to ward and school Deirdre Kane states:

> "...it really is pathetic. You grow up an awful lot but then you are not given much time to do it or to think for yourself at all. Everything is laid down. You know exactly what you're meant to do...you are just responsible for carrying out the duties you are given."

So this student recognises that the control and lack of responsibility experienced initially in the school is also a feature of ward life as she feels her wings clipped by her limited responsibilities with no room for initiative. In such an atmosphere, students experience their own low status as they identify a lack of respect for them as students and as individuals. Maire Cummins sums up how she feels about her experiences when she states: "...the whole thing here is that they're just down on you all the time..." There is another side to this reaction, as senior students can feel insulted, degraded or simply impatient, with clinical teachers or tutors who attempt to teach them in the clinical areas. I suggest that the foregoing are responses to the depowerment and low esteem evident in students' accounts of life in the classroom.

'PTS was all Pressure'

As students recount the experience of starting life in the school and in describing P.T.S., 'pressure' was a word they constantly used. As indicated in chapter 5, students experience a total evaluation through compulsory residential demands, however, this total evaluation was also related to the school of nursing. Total evaluation is not simply confined to the nurses' home or the experiences therein. Many students described a total evaluation as they discussed the 'pressures' of P.T.S. and the reasons behind their feelings of pressure - in this experience their powerlessness was confirmed. Sheila McCann, a first year student recalls P.T.S.:

S.McC "I, wondering at the time, will I be able to keep myself here?

M.T. But was there emphasis in the class on keeping yourself?

S.McC Well, there was a certain emphasis, that if you don't meet required academic standards, well obviously you're not able to do nursing, because you can't cope with all that information, and you should be able to cope with it if you want to do nursing. Also, if you can't conduct yourself...like on the wards if you can't cope with the work, if you can't learn this and if you can't learn and if you are not interested, I mean why should you be doing nursing. Look at all the other people who want to do nursing, and why should you be sitting here if you can't apply yourself to it."

Patricia O'Brien explains what she thinks was the source of the pressure: "I think this pressure was the thing of passing and failing." It does not seem to get much easier; Deirdre Kane describes her recently completed second year block:

> "...Second year block is a killer, really tough, it's all new, every bit of it and you don't even understand the notes when you're writing them down, just cramming it all in, you've exams at the end of it, and the weekends are flying.

As the tutors feel pressure and 'cram' in classroom time, so also do the students.

In St. George's students describe why they have reason to fear failure as they recall what they have seen happen to colleagues after their failure in preliminary state examinations. Carmel Macken describes the incident and how the failures were dealt with - some tutors felt that the students were being punished for failing:

> "We hear the names being called out and we thought they were going over to see matron in a group...you know we thought this is just the first group...and then I couldn't believe it!...she just called out some numbers, the girls and their names and she just said go to matron's office now and they went out and she said 'those girls have failed' and we were so shocked it was really awful. We were waiting for the results for a couple of days anyway and tension had built up anyway and no one has ever failed the prelims. You know...and then to find that some of the girls were being asked to leave...it was very upsetting.

Students, perhaps because of strong motivation to stay the course, take comments to heart and much discussion of what has been said takes place as they struggle to maintain their self-esteem and as they try to locate their place in the hospital training school. As indicated, students are subjected to total evaluation to assess how they 'accomplish profession'

(see pp. 107, 118). However, it must be remembered that this constant assessment is not simply a feature of residential life but extends to wards and schools. Students in the school of nursing receive many instructions and corrections with regard to appearance and demeanour but here another dimension is added to assessment, as the student must also measure up to academic standards. Students are repeatedly reminded by over-anxious tutors that if they do not measure up 'they're out!' Paula Jennings, describes her experience of P.T.S. assessments; the effects it has on lateral life roles are apparent:

P.J. "It's hard...you've got these assessments to get done. We are supposed to have one assessment from each tutor every week but it didn't work out quite that way.

M.T. It would be three exams?
P.J. Four exams...two anatomy, one clinical and one nursing science every week and you know you are trying to get stuff done. It was crazy and then we had projects to do on alcoholism and everything and we used to stay at them maybe until 2 a.m. to get them done, it was our own fault partly. You used to have your lectures from 8.00 until 4.30 and go to your tea around 5.30 and at 6.30 you would sort of be settled down again to study until maybe 11.00 at night."

Mary Kelly had weekly assessments whilst in P.T.S., now in her last week of P.T.S., after only eight weeks, she faces three days of assessment:

M.T. "And how many exams have you next week?

M.K. Three on Friday and four or five on Thursday, I'm not sure yet, and we have ward assessment on Wednesday.

M.T. What will the ward assessment consist of?

M.K. Well,...I might get a bed bath to do, or oral hygiene or something like that."

These weekly and other assessments serve to focus tutor and student alike. Weekly examinations whilst in school also contribute to increasing control over students, it is coupled with threats of 'if you're not good enough, you're out' (assessment, as a method of control is discussed later in this chapter). Maria Fox who had no difficulty with her studies in P.T.S. still experienced 'reality' shock. Despite not feeling overwhelmed by the

work academically, nevertheless she felt herself subject to pressure, the same message as before '...don't feel secure...even if you do well in examinations you must also conduct yourself and show interest.'

Most students comment on this pressure, which seemed to be brought about by three things:

1. The amount and newness of the material to be covered. For some candidates the acquisition of which, took up all their waking hours.
2. The reminders regarding acceptable behaviour and dress. The constant reiteration of how lucky they are to be in training and reminders that they can not be kept if they do not measure up (chs. 4, 5, and 6).
3. The constant emphasis on assessments by written examination of material covered.

I now discuss structural features of the classroom.

STRUCTURAL FEATURES

Boundaries

Students are supposed to gain their practical experience in the wards, and learn theory in the school, this immediately creates a boundary as physical distancing exists between the learning of theory and practice. Clinical teachers are expected to bridge this gap, yet they are also very aware of the boundaries. Clinical teachers only come to the school to teach the occasional session or to instruct P.T.S. nurses into the 'way of the wards'. Within the classroom, despite the tutor's 'generalist' role, teaching sessions are not necessarily integrated with each other, as the same tutor teaches a number of different subjects, and tries to 'get through all the material'. The use of visiting lecturers adds to this problem, as the content of sessions is not always discussed. Tutors are allocated P.T.S. nurses to follow through but they have to struggle to make time to see students on the wards, as they maintain their raison

d'etre, teaching and also examining, which entails correction of written papers. Thus, tutors find it very difficult and in some cases rarely get time with students on the wards. Students experience this separation between service and education, and they also realise that service takes precedence over education. For instance, they find that service needs come first and that educational needs come second. Proof of this is the practice of holding examinations while students are on night duty. Kay Feary explains:

> "I had all my exams on night duty...its terrible...and trying to study on night duty, you're just not orientated..."

Demarcation between subjects and subject separateness is emphasized in the way the timetable is planned. Each lecture session appears as a separate unit and few links exist between ward learning and school learning. Maire Cummins says: "Its a big thing...there are no links between subjects." Subject separateness may cause gaps between theory and practice. Eva Lane states:

> "Things are done quite differently from the way we learned in school."

On being asked how she coped with this she replied:

> "It depends who is around when I'm doing things, for the school I do it one way, for the ward another."

Maire Cummins states the problem:

> "There is no connection here between class and the wards, they're completely cut off - that's the way I feel about it. And yet, I don't feel its that bad, I know I give out now and I talk about it but I think I have enjoyed the time here."

Not all students felt their experience was positive. Avril Coogan writes in her diary:

> "After studying in preliminary training school for two months...I feel it should have been geared more towards actual nursing and care of the patient."

Rarely do group discussions, which might facilitate the integration of theory and practice, take place and only occasionally are study periods

allocated. Often, when they appear, instead of being part of a planned programme of study, they are used to fill gaps when lectures are cancelled or to fill the odd half hour at the beginning or end of the day. Such periods never form part of a study plan and are used only as 'fillers'.

These gaps between theory and practice are likely to make students even more scared and uncertain as in the early stages of training they also try to come to terms with a potentially frightening environment and nursing work (see ch. 7).

Methods of Teaching

As indicated earlier in this chapter methods of teaching were usually formal and students were expected to sit quietly and take notes (14). Patricia O'Brien, currently in block for what she considers a 'long spell' of five weeks, relates how discussions rarely take place in class. On the rare occasions when discussions take place, they take place with visiting lecturers. She recalls that the last time a discussion took place was in their last block, when they were doing ethics. In another block I observed this lecturer (a young cleric) using role play and getting the group to participate; I remarked on this to Patrica O'Brien saying:

M.T. "I was sitting in on the last Block and there was a priest.

P.O'B. He got people talking, whereas I find with tutors, they are talking at us and you don't ask any questions.

M.T. Why don't you.

P.O'B. Because you are afraid...because there is one tutor and if you ask questions she says 'don't interrupt me'. This is my 3rd block since I started and now I feel it is getting a tiny bit less formal...not an awful lot...I would say we were all much more relaxed with our teachers in school."

Maire Cummins, describes the nature of her experiences of classroom interaction as she recalls a classroom encounter:

M.C. "You were told first of all that you never tell a patient lies which is true enough. You can't tell a patient lies but we are also instructed that you cannot tell a patient that he is dying of cancer and I believe that she also said that you cannot tell a patient that he has cancer, that it is up to the physician. So I just said if a patient is going for an operation and naturally

enough if you're going to be sent to theatre with them, they are going to be talking to you and it's part of your job to talk to them, and reassure them, and help them relax and if they do ask you out directly, what is wrong with me nurse? what can you do - do you just stay silent?

M.T. What kind of response did you get?

M.C. A very short response it was - "what did you do in your last hospital?" I said we daren't ever give a reply to that problem and that was it and apart from the words that were spoken, I knew from the general reaction that it was not appreciated."

She contrasts the difference between this approach and that of the ethics lecturer whom I'd observed:

> "It was a priest who gave us the ethics talk and what he did was to break us up into groups first and got a group discussion going and we'd report back to him in ten minutes and then we all came to a general consensus about what was to be done and he agreed with it... The tutor told us nothing. She gave us no guidelines at all...she was offended but maybe it was just one particular person's personality...you're bound to see there that there are certain lectures given where everyone just puts down their head and writes and doesn't ask one question. Then you find that maybe someone comes in from outside and everyone is talking and asking questions especially the guy who does the biophysics. He really talks to everyone and makes the most boring stuff that much more interesting."

This student very clearly indicates how one approach to teaching enhances her self-esteem whilst the other diminishes it by making her feel ignorant. Also from the way many students described how learning took place in the school with less-favoured teachers, it would appear to be more learning by trial and error as students 'feel around' for the acceptable answers. The above encounter with the tutor is an example of this student's unacceptable answer and her response.

In St. Robert's I observe some study periods in the week's timetable and comment on this to students; however replies indicate that this was not the norm. Paula Jennings says:

> "That is just because they are very short of staff so we are supposed to be covering the stuff they would be doing with us anyway...I would say if they had the tutors we would still have our lectures blocked and I think it is better that we can go through the stuff ourselves. One of the tutors is grand you know she revises the stuff and you know exactly what has been done but others...you just sit there and you would be much better off if you had the hour to study...because you don't even have time to

digest what they are doing with you."

I also note from observation and confirm in interviews, that even in revision blocks, classroom sessions tended almost exclusively to consist of formal lecture type sessions. Within this structure, some students find it possible to ask questions; Eva Lane says: "If we want to ask a question - we all just ask it." But on the whole discussions or group work are not normal features of life in the school.

Subject Ranking

In an effort to present all the material mentioned in the syllabus, all timetable space was utilized. Within differentiation of subjects on the timetable, topics and teachers are seen in a hierarchical order. For example, in P.T.S. out of all subjects, maximum time was given to anatomy and physiology, often more than an hour a day. Practical nursing barely competed, as students had only one day per week on the ward and nurses were left to read up nursing in their own time. In contrast, anatomy and physiology was timetabled every day. This resulted in student nurses identifying anatomy and physiology as being at the heart of nursing, as in P.T.S., it was generally considered by students as the most important subject. I suggest that this commences the student's identification with the disease-oriented medical model rather than a nursing model, although nursing models are widely discussed in nursing literature (see ch. 1). Students describe the messages they picked up from the time allocated to subjects on the timetable and the way in which subjects are taught and assessed. Margaret Nally describes the emphasis on subjects in P.T.S.:

> "P.T.S. was mostly about basic anatomy and physiology, we kind of went through the basic book of anatomy and physiology and it was all sort of like more detailed biology than we had done in leaving cert, ninety per cent of it was regards that..."

When asked specifically about nursing work she said:

> "We used to have the clinical tutor in and have discussions with her, they used to come into us in block and discuss what we had done on the wards and what they expected from us, I don't ever remember actually sitting discussing the nursing role."

This also results in knowledge coming to be seen in a hierarchical fashion. In P.T.S. the subject the students considered most important on the timetable was anatomy and physiology. On being asked about study in P.T.S., Mary Connolly replies:

> "I did not think there was so much studying involved...all that anatomy and physiology...we got help though...we were split into groups for the main subject...anatomy and physiology."

And in St. George's when asked what subjects she covered in P.T.S. Rosemary Armstrong said:

R.A. "Well there was practical and anatomy and physiology, and loads of other things like microbiology and all those things. I would say basically, you really do have to have a very good knowledge of anatomy and physiology, because if you don't understand where to group the organs outside the body, well how can you apply your practical work? How can you even understand your practical work after that?

M.T. Did you do any psychology in P.T.S.?

R.A. Yes we did psychology. I wouldn't feel in P.T.S. psychology was very relevant. I can't really remember very well...it didn't seem relevant to me at the time."

Maire Cummins a second year student states the subjects she thinks most important:

> "Straight away I would automatically say the medicine and surgery, but I think the lectures are a pure waste unless you can actually picture somebody from some practical experience that you have had and when you have that experience the lecture just falls into place..."

Medical based subjects appeared to receive more priority, being seen as what was needed for examinations. There was much less emphasis in the timetable and in examinations on a range of other subjects like sociology, psychology and health education (15). Although listed in the syllabus, these latter subjects rarely appear directly on the examination papers, consequently students take them less seriously. Nursing is defined as something which can be 'learned on the job' or read up in one's own time - hence the day a week in groups with a clinical teacher on the ward. Very often, student nurses are left to read up nursing on their own, reading

about how to carry out the procedure i.e. perform the task. Ruth Sweeney describes how she covered care of the dying in P.T.S.:

> "I have read it alright, we have been told to read it but we haven't discussed it as yet in class unless somebody dies when I am there <on the wards>. I do not think it is practical for the tutor to cover it."

This student in her eighth week of P.T.S. is almost certain to encounter death and even have to lay out someone before her next block. She finds that she is left to link theory and practice. Eva Lane, a student about to sit her end of P.T.S. examinations (one of which is a nursing assessment on a ward doing e.g. a bed bath), when asked, if exams are important responds:

> "Yes. You have to repeat them. I heard you go if you don't get them."

But she goes on to suggest:

> "They are important to make sure you know your stuff, you wouldn't do it otherwise but as far as perhaps the nursing is concerned, the nursing aspect, maybe it isn't."

Consider the messages in the above - fear of 'having to go' and nursing not being as important an examination as other subjects. When asked if she spends maximum time on nursing in P.T.S. - Mary Kelly replies:

> "No, I don't think so. The way it works is...there are certain parts of the book allocated to be done each week and we do them ourselves. We read them ourselves and if we have any questions - the tutor reads over the chapters we have to do and we discuss it if there is any added information. Then we carry out these procedures in the ward. It is the most important subject. Then anatomy and physiology...it's just that there is so much to be covered in anatomy and physiology. Anatomy and physiology is more heavy, there is much detail and fact whereas nursing...as well as learning the procedure, a lot of it is logical and you have to use your initiative.

This P.T.S. student interprets differently. As she sees it, nursing is the most important area despite not spending most time on it. Yet she feels anatomy and physiology is also important and justifies spending so much time on it. The fact remains that much of nursing is covered by reading when school hours are over or is learned 'on the job' (see ch.7). This creates a subject ranking in the student's mind.

LEAVING SCHOOL BEHIND

Students as they leave the school after P.T.S. have little motivation to return to it, they can now do what they came into nursing to do - have patient contact and provide direct patient care.(ch.7). Subsequent blocks have only one advantage as far as most students are concerned - regular hours with weekends off; one of the few times when off duty time is more or less guaranteed and one of the few occasions when students, who work a six day week, have a chance to get weekends off and meet old friends (16). Patricia O'Brien describes her attitude:

> "It's a change, and also I wouldn't have met an awful lot of the girls in my set for a couple of months because they were on night duty and I was on days, and it was a great time to meet them again. I didn't look forward to coming into this block because I knew it was a revision block and there was pressure therefore, I wouldn't mind for a couple of weeks here and there but not for a long spell."

This sums up the views of many students towards their school experience, it is not something they value or look forward to.

SUMMARY

To summarize, students experience hierarchical control in the school of nursing. Even within this educational setting, they experience subordination. Within this context, the formal methods of teaching and separation between subjects on the timetable suggest to students that they are expected to simply absorb what is presented to them; they also contribute to students identifying a hierarchy of knowledge forms in the rankings given to certain subjects. Students reported gaps between theory and practice, as they failed to relate theory to ward experiences; their relationships with teachers and the ways in which they were taught failed

to facilitate integration.

From the tutors' accounts it was apparent that they also experienced a relative powerlessness as they too were controlled. They could do little to change the student experience of training either in the classroom or on the wards. Nurse training is hospital training, and service hospital workers control that experience (17). For both students and tutors alike the school of nursing replicated the hierarchical structures of clinical areas both in terms of personnel, subjects taught and control over day-to-day work. I suggest that the initial two months in P.T.S. (perpetuated in later blocks), with its rigid timetabling, lack of emphasis on self-directed learning, tight discipline, and the maintenance of divisions between students and tutors, helps to maintain the status quo in nursing and in the hospital, as it presents and perpetuates definitions of nursing and hospital practice.

DISCUSSION: HIDDEN ASPECTS OF THE FORMAL CURRICULUM

The first part of this discussion relates to data presented in this chapter, the second part (p. 215), relates to data presented in this and the preceding two chapters. As indicated (chapter 2), it was considered that Bernstein's (1971A) work on the social organization and the structuring of educational knowledge might help to understand the process of professional socialization as it focuses on the context of socialization. It highlights hidden aspects of the formal curriculum. This conceptual framework is now discussed in relation to the data presented in this chapter. Bernstein (1971A, p. 47) states that educational knowledge is realised through the following message systems:

> "Curriculum defines what counts as valid knowledge, pedagogy defines what counts as a valid transmission of knowledge, and evaluation defines what counts as a valid realisation of this knowledge on the part of the taught."

He makes the distinction between collection type and integrated type curricula. When contents "stand in a closed relation to each other", and are clearly separated and insulated from each other then a collection type curriculum exists. Where contents are not separated but "stand in an open relationship to each other" then an integrated type curriculum exists (Ibid. p.49).

The theoretical constructs of classification and framing are put forward to clarify discussion of the form of knowledge and its relationship to the control of knowledge. Framing is defined by Bernstein (1971A, p.50) as follows:

> "Frame refers to the strength of the boundary between what may be transmitted and what may not be transmitted in the pedagogical relationship. Where framing is strong, there is a sharp boundary, where framing is weak, a blurred boundary, between what may and may not be transmitted. Frame refers us to the range of options available to teacher and taught in the control of what is transmitted and received in the context of the pedagogical relationship. Strong framing entails reduced options; weak framing entails a range of options. This frame refers to the degree of control teacher and pupil possess over the selection, organisation and pacing of the knowledge transmitted and received in the pedagogical relationship."

While classification:

> "...does not refer to what is classified, but to the relationships between contents. Classification refers to the nature of the differentiation between contents. Where classification is strong, contents are well insulated from each other by strong boundaries. Where classification is weak, there is reduced insulation between contents for the boundaries between contents are weak or blurred. Classification thus refers to the degree of boundary maintenance between contents. Classification focuses our attention upon boundary strength as the critical distinguishing feature of the division of labour of educational knowledge." (Ibid. p.49)

Knowledge codes are classified as collection codes depending on the strength of classification and framing. Strong classification and strong framing result in collection type curricula, while weak classification and weak framing result in integated type curricula. I now discuss these in relation to structural features of the nursing classroom.

Structural Featuress of Nurse Training

As illustrated in this chapter, in the nursing classroom, an emphasis on hierarchical control exists, with little individual responsibility. Students find themselves subject to correction and surveillance, and as formal teaching methods prevail little opportunity exists to be more than passive recipients of transmission-type teaching (Barnes, 1976); in this sense, framing is strong. Likewise, classification is strong as rankings of, and divisions between subjects are seen to exist. In the nursing classroom, both classification and framing are strong for the student nurse, giving rise to a curriculum of the collection type.

Classification and framing are also strong for tutors, as they are constrained by a syllabus and examination structure which emphasises certain subjects (i.e. 1st year state examination, of which one of the two papers is devoted to anatomy and physiology <see appendix V1A>). Tutors have little control over content or context of teaching sessions and must simply 'fit-in' with various specialist lecturers. Tutors have no real power in the hospital training school and are unable to bring about change. The controls experienced by tutors, are in turn, experienced by student nurses in the school of nursing. Tutors experience a lack of control, having little choice in the subjects they teach, they find they are expected to be 'jacks of all trades' and to teach everything; as Pamela McKeown says 'tutors are generalists', not specialists. Alexander (1982) also notes the way in which nurse tutors are 'generalists'. I will now consider features and implications of strong classification and frame in more detail.

Strong Classification and the Student Nurse

Classification refers to boundaries and separation between subjects. In nursing education, classification is strong for student nurses, with rigid demarcation between subjects on the timetable. Subject separateness

is emphasised in the way the timetable is planned. A demarcation between teaching periods is visible with sessions disconnected from each other i.e. students may find themselves doing physics in one session, and psychology in the next, each lecture is a discrete unit. Despite overlap between subjects, very little discussion of the timetable takes place. Consequently when tutors start teaching a subject they could be informed by students that Miss M. says this or Dr. N. says that. For example, child development might overlap with psychology or paediatrics or paediatric nursing but invariably three or maybe four different people would teach these subjects as separate entities with no communication as to the areas each had covered.

Likewise, timetabling (in terms of placing and time allocated), coupled with a transferral of hierarchical arrangements from the hospital, represents a ranking of subjects. Anatomy and physiology is considered more important than psychology and sociology by 1st years, and medicine and surgery are considered the most important subjects by more senior students. Wyatt (1978, p. 270) reports how in his study of student nurses the word theory was associated with anatomy and physiology. Bernstein (1971A, p.50) says such "strong classification...creates a strong sense of membership in a particular class and so a specific identity." The question is, if for nurses a strong sense of identity and membership is created, not with the nursing profession as a whole but, rather only with nurses who work in the same area, with their training hospital and more especially with medicine?

Strong Classification and the Tutor

For the tutor, classification is also strong, as boundaries are drawn and she finds that she has little control over content of teaching or even mode of transmission. Tutors experience a 'lack' of status in the hierarchical institution, as they find that they have little real control over, or responsibility for, planning a day or a week in block. Where they

are 'responsible' it is usually within a given structured framework e.g. the tutor whose responsibility it was to book Mr. Smythe's lectures for the 2nd year block (see p.171). In the course of their work, tutors experience a rigid hierarchical structure and are faced with a predetermined ordering and presentation of knowledge in the classroom; no real room exists for them to dialogue with or influence those who control the institution. Tutors, like many other workers within the hospital, are assigned a specific task to perform with strict limitations and controls.

It is interesting that tutors as 'generalists' (as opposed to specialists) find themselves in a situation of strong classification; I suggest that this occurs partly through their separation from the ward as 'education specialists', through the use of the 'checklisting system' and through the use of many specialist visiting lecturers. It is a feature of tutors' lack of control that they are not allowed to specialise in subject teaching and to be responsible for teaching certain subjects. Neither are they allowed to act as 'cement fillers', as one tutor put it, in terms of integrating material. Students' 'time' never seems to be set aside for this 'gelling' as ward and school are rarely brought together. Service requirements dominate the school, as does the emphasis on syllabus content through the checklist system. This lack of subject integration can cause gaps between theoretical and practical knowledge. I suggest that visiting lecturers and rigid 'checklist' systems contribute to strong classification for both student and tutor.

Implications

For the student nurse, strong classification is likely to have the following effects:

1. As some subjects dominate the timetable students appreciate what it is important for them to know; some subjects come to be seen as more important than others (non-medical related subjects like psychology and sociology, and I would suggest, even nursing theory, can lose out).

2. It can create a strong sense of identification with a group and I tentatively suggest that some students end up identifying with higher status medicine rather than nursing as the hierarchical arrangements of the ward are carried over to the school.
3. It creates and maintains gaps between theory and practice.

For the tutor, strong classification prevents her acting as an 'integrater' of the various subjects presented.

Strong Framing and the Student Nurse

Framing refers to the structure of the message system, it relates to the control of knowledge. In the nursing classroom, framing is also strong as students find themselves in a structure that is rigidly controlled. Bernstein (1971A, p. 58) states that the stronger the classification the more hierarchical the relationship and the more the student is seen as "ignorant with little status and few rights". This implies that feelings of humiliation and lack of control may be engendered by strong framing, as pupils find that they have little or no control "over the selection, organisation and pacing of the knowledge transmitted and received in the pedagogical relationship" (Bernstein 1971A). Sarah Kenny indicates the control that is the norm for the student nurse in the school of nursing (see p. 191). Strong framing is further emphasised in the layout of classrooms (see appendix IIIA). This organization of space presents the emphasis on formal teaching that is apparent in the classroom setting, it further reduces the power of the student.

Strong Framing and Tutors

Framing is strong for tutors who are very aware of the need to get through material and because of this they could not allow themselves to be sidetracked from their subject matter in the classroom. Therefore, little room existed for dialogue between teacher and taught. Tutors also experienced powerlessness, as they found themselves confined within the

same hierarchical structure as the students. Having little opportunity to influence superordinates or freedom to plan blocks, their powerlessness was exacerbated by the 'checklisting' system. They found that classroom teaching, content, pacing and timing of transmission were rigidly controlled by factors, such as the general organization of the school, service demands and a syllabus and examination structure geared to demonstrating knowledge acquired rather than ways of knowing.

Implications

For the student nurse, strong framing may result in the following:

1. As well as contributing to a hierarchical view of teachers and learning and knowledge, the lecture-recitation method shifts responsibility from the student for her own learning.
2. Students become passive and do not take responsibility for their own learning and development.
3. As students are depowered, they feel ignorant and devalued.
4. They uncritically accept information as transmitted.
5. Gaps between theory and practice are created or perpetuated, as dialogue between teacher and taught is precluded or limited.

For the tutors strong framing means less control over their work.

STRONG CLASSIFICATION AND STRONG FRAMING: A DISCUSSION

It is suggested that strong classification and framing are features of control in the organization which structures occupational role identity for the student nurse. Bernstein (1971A; pp. 50-51) states that where classification is strong, divisions between various contents are clearly drawn, and this assumes 'strong boundary maintainers'. He suggests that strong frames lessen the control of the pupil over content, timing and transmission of knowledge and increases the power of the teacher in the

relationship with pupils. But he further points out, that strong classification decreases the control of the teacher over what is transmitted as he is unable to step outside the boundaries between contents, and it also reduces the power of the teacher in relation to the 'boundary maintainers'. He further indicates the way in which wider power structures may influence educational codes when he states:

> "It can be seen that the nature of classification and framing affects the authority/power structure which controls the dissemination of educational knowledge, and the form of the knowledge transmitted. In this way, principles of power and social control are realised through educational knowledge codes, and through the codes they enter into and shape consciousness." (Ibid, p.54)

Findings of strong classification are a feature of another study of nursing. Clinton (1984, p.12) in his study of psychiatric nurse training writes that "Bernstein's model implies that nursing knowledge is formally transmitted through a cultural code of the collection type." In relation to his findings of strong classification and framing, he suggests:

> "This lack of integration in nursing curricula arises from the 'patient-centred' rhetoric which pervades classroom sessions." (Ibid. p.12)

However, as will be seen, I suggest the origins of such lack of integration lies in strong framing and transmission-type teaching coupled with the strong service ideology of the hospital; the message arises not from content but from organizational features of the school of nursing.

What is regarded as legitimate knowledge in nursing, is not determined by tutors (although nursing textbooks in use may espouse a nursing model), but by the power structure within which nurse training is provided; it is very much a power structure of medical dominance. This structure has been noted elsewhere, (Melia, 1981; Buckenham and McGrath, 1983; Rosenthal et al. 1980). Rosenthal et al. go so far as to suggest that change in nursing cannot take place unless these power structures change. Another way to consider this factor is to look at the fate of educational influence. It is suggested in this study that lasting educational (school of nursing)

influence is minimal as little dialogue takes place between teacher and taught. Where educational influence is brought to bear it tends to be a form of medical domination. Medical dominance is contributed to by strong classification in the curriculum, as doctors are authority figures both in the classroom and the ward. I suggest however, that piecemeal changes in schools of nursing are of little effect, and that the structuring, content and presentation of the curriculum are but representations of the wider power structures within which training and indeed nursing takes place.

Theoretical v. Practical Knowledge

It is suggested that strong classification and framing may maintain gaps between theoretical and practical knowledge for students (Bernstein, 1971A, p.58). For tutors who recognise the gaps, a 'personal conflict' is created as they identify the gaps and sometimes the solutions to the problems, yet are powerless to do anything about them. In discussing theoretical versus practical knowledge, Bernstein (1971A; p.58) says that educational or school knowledge is 'uncommonsense' knowledge, that is, knowledge that is not local, not everyday and that this highlights the need to ask questions regarding:

> "...the relationship between the uncommmonsense knowledge of the school and the commonsense knowledge of the pupil, his family and his peer group."

He further suggests:

> "...that the frames of the collection code, very early in the child's life, socialize him into knowledge frames which discourage connections with everyday realities, or that there is a highly selective screening of the connection. Through such socialization the pupil soon learns what of the outside may be brought into the pedagogical frame."

Given Bernstein's (1971A) formulation, the separation of commonsense everyday knowledge from the world of esoteric school knowledge can be identified in the case of nursing as giving rise to a separation between the commonsense everyday knowledge of the student and of ward life (i.e. practice), and the uncommonsense knowledge presented by the school of

nursing (i.e. theory). As indicated, because of strong classification and strong framing, few opportunities exist for student nurses to bring their level of reality (commonsense understandings) to the nursing school. Conversely, I suggest that as students struggle to cope in the clinical areas and learn by 'trial and error' it is that untouched commonsense knowledge upon which they draw (see p. 250). Wyatt (1978, p.270) notes that student nurses in his study frequently reported 'your real learning is doing the job'. If teaching methods do not incorporate the student's reality into sessions presenting uncommonsense knowledge, then the two never meet in a dialectic and commonsense knowledge remains the basis for day to day operations. In the course of this study, however, some students did undertake preparation of projects for presentation in class but often without sufficient basic information and without guidelines regarding the limits of their projects. This resulted in extreme anxiety for some and indicates the undesirability of extremes. Something of the purpose of student-teacher dialogue is exemplified by Freire (1972, p.61) when he states:

> "If it is in speaking their word that men transform the world by naming it, dialogue imposes itself as the way in which men achieve significance as men. Dialogue is thus an existential necessity. And since dialogue is the enounter in which the united reflection and action of the dialoguers are addressed to the world which is to be transformed and humanized, this dialogue cannot be reduced to the act of one person's 'depositing' ideas in another, nor can it become a simple exchange of ideas to be 'consumed' by the participants in the discussion.

Bernstein (1970, p.347) puts it another way when he says:

> "If the culture of the teacher is to become part of the consciousness of the child, then the culture of the child must first be in the consciousness of the teacher".

Pring (1976,pp.126-7) makes a similar point when he states that a theory of education must have a theory of mind, and central to that development of mind is the growth of knowledge, but such theories must not have too narrow and too neat a theory of what that knowledge is "and thus an inadequate concept of mind" (Ibid. p.2). The argument is made to allow

pupils to draw on their own commonsense knowledge thus enabling them to have a more active role in their own education. Pring (1976, p.126) points out:

> "...the understandings brought to the school not only serve the learner well for a large number of purposes but they (unless they receive sympathetic but critical attention of the educator) will remain untouched by the school and will remain the dominant influence in how the pupil continues to think, feel and approach life's problems."

He further explains:

> "Part of what is meant by 'educating commonsense' is the attempt to get the pupil or student to reflect upon, to look critically at, to make explicit the assumptions of what is already 'known'...words can be memorised...But their connection with reality - the practical, commonsense reality in which the pupil 'really' operates - is lost." (Ibid.pp.121-3).

In nurse education, if the 'connection with reality' is lost, then not only is a student's contribution devalued resulting in poor self image but, the student fails to relate theory to nursing practice and consequently may be even more 'at sea' in the 'stress bed' of the hospital. This is the problem which Bernstein (1971A) suggests occurs when pupils' own commonsense knowledge is ignored. I suggest that the relevance of the foregoing to nurse training is apparent if one considers ward experience as 'the local, the particular', an area where the learning of commonsense knowledge takes place; and school knowledge as 'uncommonsense knowledge'. So the gap between theory and practice may be seen as a gap between 'commonsense' and 'uncommonsense' knowledge; as the failure of school knowledge to permeate the student nurse's everyday knowledge.

Thus, within the context of nurse training, where student nurses are not simply exposed to theoretical knowledge but are also exposed to work experience in a clinical setting, gaps of this kind are to be expected. However, from the situation described in the school of nursing, it seems that educational structures fail to deal with the problem, as exchange and

dialogue between teacher and taught are rare. As indicated in this chapter, student nurses have difficulty making connections between theory and practice, a problem extensively recorded in nursing literature (Working Party Report, 1980; McGowan, 1979; Clinton, 1984; Bendall, 1975; Melia, 1981).

Control of Pedagogic Practice

As indicated neither teacher nor pupil determine pedagogical practice. Tutors often have to account for classroom work on an hourly basis and are therefore incapable of initiating change in educational practice from within the classroom without 'outside' supports. In the case of nursing, teaching methods used are also determined by organizational factors. Consider how the working hours of the ward were carried over to the school. Adelman (1977, p.234) points out that school teachers have little control over pedagogical practice, this being determined by the organization of the school and society's established moral codes. The demand in nursing for more classroom time for students or more ward time for tutors, can change little unless the nature of the pedagogical relationship and teaching methods change. Given the hierarchical structure of hospital nurse training in the schools of nursing and a tightly packed unintegrated syllabus, organizational change would seem to be a necessity if problems are to be addressed and change to be effected.

In Bernstein's terms, both classification and framing of educational knowledge in the school of nursing are strong, giving rise to what he calls a cultural code of the collection type. He states that tensions between collection and integrated type curricula arise out of very different authority patterns and concepts of order:

> "...under collection order arises out of the hierarchical nature of authority relationships, the systematic ordering of the separate contents, an explicit relatively objective examining system, under integration order is something that has to be developed and planned." (Bernstein, 1975, p.84).

and he states:

> "For the many, socialization into knowledge is socialization into

> order, the existing order, into the experience that the world's education knowledge is impermeable." (Bernstein, 1971A, p.57)

Through the student nurses' initiation into nursing knowledge she is socialized into the order that is an unchanging feature of hospital life.

EVALUATION, ASSESSMENT AND THE 'INSTITUTIONALIZATION OF INNOCENCE'

The following discussion relates to accounts of students' experiences presented in this chapter and in chapters 4 and 5. It has been suggested that evaluation of knowledge is also bound up with patterns of authority and control; forms of evaluation, of testing exist that are appropriate to the curriculum and pedagogy. Bernstein, (1975, p. 85) states:

> "...evaluation defines what counts as a valid realization of this knowledge on the part of the taught."

In the hospitals studied, where strong classification and framing exist, evaluation is a 'reflection' of the authority structure. It reflects the nature of authority and control in the hospital training school. Bernstein (1971A; p. 57) suggests that with collection code evaluation, states of knowledge are assessed rather than ways of knowing. In the schools of nursing studied, assessment by written test is common, with many students sitting weekly tests; tests which in their eyes come to be of paramount importance. Yet, these tests as tutors indicate, may mean little because of their lack of power as tutors: Students fail examinations and still stay the course. Ward assessments also exist and are given more official weight (18).

Students' accounts of training experiences and more particularly their accounts of 'pressure' presented to date in this thesis, are not totally explained within Bernstein's (1971A) framework, other than in a very general way as the outcome of evaluation. A fuller understanding of

this 'pressure' is represented in Metz's (1978) accounts of 'the institutionalization of innocence' and the control of schoolchildren. In discussing the fragility of order in the school, she notes that: "order is a constant problem because schools' resources for control are slim and uncertain" (Ibid. p.59). She cites Etzioni's (1964) three available modes of control; normative; utilitarian and coercive (19). Metz (1978, p.60) indicates that these may not be sufficient or possible forms of control for schoolchildren and suggests the school responds by trying to generate "an illusion of greater resources than they could actually exercise if pushed by disobedience." In her description of labelling innocence, Metz suggests that adults foster an innocence in children to get them to accept things. She states:

> "...they generate a calm expectation of compliance, which suggests to the students that disobedience would bring shocked disapproval and awesome, though vaguely conceived punishment. This method of control could be called the institutionalization of innocence." (Ibid. p.61)

However, she suggests that if students do not expect to profit from participation, or if school routines demand students to change habitual behaviour then this form of control cannot be used. In such case, a related form of coercive control may be used "which concentrates upon establishing in students' minds a myth of the awesome coercive power of the school" (Ibid. p.61). In this way the school's weakness, in terms of an absence of real resources for control, does not become known. Metz indicates that this form of control requires organization of all behaviour so that infractions are easily visible; and first visible infractions must be dealt with most severely, swiftly and consistently, and punishments should be of a 'few exemplary offenders'.

In the hospital training schools studied, where changes in behaviour and appearance were demanded and where students were well motivated, normative control is present, but accounts also suggest something of the

latter more coercive form of 'labelling innocence'. Consider chapter 4, where new initiates were told "we've standards here...if you can't keep up...if you don't measure up...you go!" and so the illusion begins, that is, 'we may have accepted you for training, but we don't have to keep you...people's lives are at stake here' (20). Residential life affords more opportunity for control, and according to Metz, strongly coercive control of this kind, requires the exposure of residential life. In nursing, students find that appearance and behaviour may have to change as they live-in, are exposed to surveillance and correction and demonstrate that they are 'accomplishing profession' (see pp. 107, 118). It is noteworthy that living-in arrangements are compulsory only in the early stages of training. Perhaps as hospitals initially demonstrate control, later on they can maintain the illusion?

In the early days, the possibility of high attention to minor infractions creates and maintains an illusion of control. It perpetuates the illusion that 'you may have to go', as occasionally, minor infractions are dealt with most severely. The hospital training school is not adverse to delivering exemplary punishments when in a position to do so. For student nurses compliance with rules is demonstrated to be important as examples are made of 'offenders'. This begins as verbal admonitions, but students may witness severe treatment. Few students could name someone who had to leave (many stories were second and third hand), but all students believed it a possibility to the extent that they felt the need to 'fit-in' 'avoid hassle and notice', generally, 'keep a low profile' and 'study hard and pass examinations'. In the course of these experiences the student learns of her own low status in the hospital hierarchy and of her own powerlessness; this serves to support the illusion. The 'pressures' recounted by students in their accounts in this chapter reflect the creation and maintenance of a successful illusion as students accept 'if you don't pass, you're out'. On the other hand, tutors report that no

one listens when they complain that students have failed all examinations and are not up to standard. So student nurses think evaluations and assessments are important, while tutors know there is little they can do to get rid of a 'bad' student. However, it's not simply illusion, as the occasional student gives into 'pressure' and leaves, despite matron saying of a 'difficult' student 'she's in and we're stuck with her' (21).

The feeling of evaluation is added to by the uncertainty associated with the type of ward assessment in use. Assessment as it stands can be a means of maintaining uncertainty for and control over student nurses. For example, student nurses know that they must get three 'good' ward reports in their first year, but often do not know when these reports may fall due (i.e. on which wards they will be assessed), or the basis of assessment. So on wards they try to satisfy, to fit-in, to keep busy, without really knowing what will form the basis of assessment. This acts as a mechanism of control. In nurse training the illusion of control is maintained through tests and assessments (22). Evaluation, as demonstrated in chapters 4 and 5, is present in other ways as students realise they are 'being watched'. The hospital, in setting itself up as acting in <u>loco-parentis</u>, contributes to this coercive form of 'institutionalizing innocence'. As the student is told 'we're responsible for you' - does it mean to them 'we have control of you'?

As is apparent, this 'institutionalization of innocence' is not unrelated to the strong classification and framing and the collection code suggested by accounts of student experiences in the classroom, or indeed, to the residential arrangements and hierarchical structures throughout the hospital training school. Metz (1978, p.61) suggests that structures must support controls; she states:

> "To instill such a perspective, the character of the school must be unified. It must be standardized and routinized. Not only the temporal and spatial routines but the definitions of relationships and even the curriculum itself must be presented in

a similar way in each classroom."

She continues:

> "Schools using these patterns of control require structures that will support unity of style and procedure. Such structures involve clear hierarchy and centralized decision making about everything from the curriculum to ball passes."

Accounts indicate that with the collection code in the schools of nursing, tutors were unable to make an individual judgement, or decision, and tasks were rarely delegated with authority e.g. interviewing prospective students. I suggest that the strong classification and strong framing indicated by the preceding accounts in this chapter create the unity of style and procedure necessary for the maintenance of this form of control in the school of nursing. As accounts in chapters 4 and 5 suggest, the 'institutionalization of innocence' is a form of control, exercised successfully throughout the hospital training school.

CONCLUSION

This chapter presents students' and tutors' accounts, and analyses experiences in relation to structural features of the school of nursing; it emphasizes the importance of considering structural aspects of the educational process in studies of professional socialization. It would seem that the structural aspects of the educational process, coupled with the experiences described in chapters 4 and 5, suggest first and foremost a system of control, based on depowerment and uncertainty (see 'pipeline status' ch. 8). I suggest that life in the school of nursing for the student nurse is but an extension of her experiences of total evaluation (chapters 4 and 5).

What is apparent from the accounts in this chapter, is that the social relationships of formal knowledge transmission are structured in such a way in nursing schools that nurse tutors discretion is reduced as well as that

of students. Yet, Bernstein suggests that with collection codes, teachers' discretion is increased (paralleled by the reduced discretion of pupils), but within the limits of existing classification and frames. In nursing, tutors do find their discretion controlled and reduced as they operate within a wider power structure (23). The question arises if this applies only to schools of nursing or if it applies to other educational institutions? What other types of institution create the potential for control and depowerment described to date in this study? How much of these accounts are directly related to the position of nurses as women? These are questions relevant to these accounts and which are raised by the present study. Bernstein (1975) suggests that collection codes, result in gaps between commonsense and uncommonsense knowledge and such an effect is reflected in students' accounts of 'leaving school behind'. This implies a 'lasting' effect (until counteracted) on students' work roles, as they fail to draw on theoretical knowledge in the course of their work. While not addressing the issue of persistence directly, I suggest that it equips them only for work in a particular type of organization with clearly defined roles, guidelines and routines i.e. a bureaucratic structure. Students experience of working within this setting are presented in chapter 7.

In nurse training, there may be dimensions to evaluation and assessment other than that elaborated by Bernstein (24), and I suggest that Metz s 'institutionalization of innocence' helps to expand the concept of evaluation and assists in the understanding of student nurses' numerous accounts of experiencing 'pressure'. Metz indicates, and I concur, that there is of necessity a tension between order and education. In discussing control, centralized decision making, and unity of style, she states:

> "Such structures and such a curriculum and style of teaching may support order, but they are hardly to be recommended for maximally effective education." (Ibid. p.61)

Bernstein also indicates this in discussing the gaps that arise in collection codes between commonsense and uncommonsense knowledge. This raises questions in relation to wider issues in nurse education and is discussed further in chapter 8.

In chapter 2, it was indicated that this study was within the acculturation tradition of earlier socialization studies. However it was suggested that those earlier studies failed to take account of the hidden messages transmitted in the course of training, and on the whole, ignored structural influences on socialization experiences. Armstrong (1977) suggests the importance of structural aspects in transmitting definitions of disease to medical school students, while Atkinson (1983) pointed to the need for studies of professional socialization to consider theoretical developments in the sociology of knowledge and in so doing to consider structural aspects of the educational process. Many studies of transmission and acquisition of occupational beliefs and attitudes implicitly accept the existence of an informal agenda or a hidden curriculum of the formal curriculum. However, they do not make any attempt to examine the informal agenda and relate it to students' experiences, consequently they fail to deal with an important aspect of the socialization experience. As Atkinson (1983, p. 233) points out, Becker's hyperbole that "school is a lousy place to learn anything" seems to deny that the 'process of training' is the focus of their studies. He states that it:

> "boils down to the interactionists' failure adequately to cope with problems of knowledge and to produce a sociology of the school curriculum." (Atkinson, 1983, p.234)

As suggested in chapter 2, reaction approach studies assign students a role where they actively participate in their own socialization. However, this chapter and chapters four and five suggest that limits may be imposed on the students' development of their role by a system of control. As this and preceding chapters indicate, students are often aware of the

controls imposed on them and are not simply the pliable puppets of induction approach studies. The perspective of this study as outlined (chapter 2), suggested that consideration of both 'objective and subjective reality was important in understanding students' accounts of their training experience'. In the light of this, the present chapter focused on a structural analysis of life in the school. At this stage I must point out that in the hospital training school, concerns other than education are at issue; part of the context of training is the student nurse as worker (as indicated chapter 1) - as paid service employee of the hospital. The student nurse must provide safe patient care in the course of her daily work. The next chapter - 'The Life of the Ward' - considers that aspect of student life and how the student nurse is assisted in that role by the order and control imposed in the hospital training school.

FOOTNOTES

1. In the three schools of nursing I looked at staff/students ratios were as follows:

	Tutors (including Principal Tutors)	Clinical Teachers
St. Paul's	245:6	245:3
St. George's	325:6	325:5
St. Robert's	157:3	157:0

2. The size of student intakes vary, but in larger schools intakes may be split into two groups so that students can expect to find themselves in groups of usually around twenty five. In some cases groups are composed of as many as forty plus where earlier intakes are increased in size in block due to the presence of post-registration students.

3. Time in P.T.S. varying from six to nine weeks in different schools of nursing. Schools of nursing have two intakes of students per year usually around March/April and late August/September.

4. Of the three hospitals I studied, two had their schools located within the hospital complex and one, for reasons of space, a little outside it.

5. Although, only a small number of tutors were interviewed formally, the material presented was raised in informal meetings during the course of participant observation with all tutors in the schools of nursing

studied.

6. Because service and education both come under the rubric of service, schools do not have an independent budget for outside lecturers, visits, hire of videos, films etc.

7. First year state examinations i.e. registration part one consist of two written papers; one devoted exclusively to Anatomy and Physiology and the other entitled General Principles of Health, Nursing, First Aid, etc. and includes nursing, first aid and hygiene etc. (see appendix V1A).

8. As indicated in chapter 3, when gaining access to hospitals, I also used my ward experience as a credibility factor in presenting myself as a suitable person to study nurses.

9. These assessments are Nursing Board requirements and each student must get three such satisfactory reports during the first year of training. These three satisfactory reports become the basis for matron's formal support of the student's registration part 1 examination candidature. Similarly, before sitting the registration (finals) examination, students must obtain a further four proficiency assessments. Dilemmas are posed at different stages for the ward sister who may be reluctant to 'black' a student's career and who may not be prepared to take on this responsibility on the basis of her limited student contact over a twelve week period; or for the matron who is faced with a damning report on a 3rd year student whose other two reports were reasonable. I was present when such a dilemma was passed on to the school of nursing and the candidate only weeks from her state final examinations. She was allowed to continue and complete her final examinations because it had been left too late to take action. The report had concluded with "I would not be happy or prepared to leave my patients in this nurse's charge". It seems that this assessment is meaningless being informal and haphazard and based on only an ambiguous assessment of a student's work (see appendix V1B for a sample of the proficiency assessment form).

10. Principal tutors, along with matron sign the student's certificate of instruction for registration examinations (see appendix V1C). Tutors do, of course, correct state examination papers, but at a local level it is in ward sisters' hands that assessment of practical proficiency rests.

11. Abolished only recently (1982) by An Bord Altranais in State examinations but some hospitals still use doctors in house examinations. See appendix V1E for an indication of doctors' involvement in student nurse teaching.

12. A list of the items to be covered for each block - to be dated and signed by the tutor as covered (see appendix V1D). Two of the three schools tightened up their checklisting system, and student records, due to imminent inspection by An Bord Altranais (1983).

13. This formality is apparent in the layout of classrooms, all of which were set out with rostrums at one end of the classroom for teachers, thus creating a barrier as students occupied their own classroom space and sat at tables and chairs facing teachers.

14. Wyatt (1978, p. 271) in his U.K. study reported very low scores for

students' use of study block "to discuss your practical experience with a tutor". Three per cent, four per cent and eight per cent respectively of 1st, 2nd and 3rd year students reported that they use study blocks in this way.

15. This is evident from interview accounts of tutors, perusal of timetables and examination papers.

16. Wyatt (1978, p.271) reports that students in his study (fifteen per cent of 1st years, forty six per cent of 2nd years and thirty seven per cent of 3rd years) said the best feature of block was "to live a normal life for a change".

17. However, the experience is in turn controlled by the institutional requirements of an acute carè setting. Control by Bord Altranais over the educational side of nursing is strong in some ways, yet, weak in others. It is strong in terms of control of syllabus, content of clinical experience and examination structures. After this it becomes weak as a number of schools (27) operate in different ways depending on size, facilities etc. (Working Party Report 1980). However, interpretation of the syllabus is such in the case of the three hospitals studied, that it resulted in very inflexible application of the syllabus with little interpretation or very limited room for interpretation given service influence. In the light of the controls imposed by service based training (Dept. of Health funded) and the need to justify students' and tutors' (salaried) classroom time, this narrow interpretation is likely to be the norm considering the extent and nature of the syllabus, the work role of the student in clinical practice,and the examination structures. Within the current system in this study, I observed individual tutors indulge in less formal encounters with students with attempts to move towards an integrated approach but as will have also been seen in this chapter, frustrations are high and success rate in terms of integration, is low.

18. Ward assessment is discussed here as an example of the complexity of nurse training. One very important issue raised in this chapter is the question of ward assessment of student nurses. As indicated, tutors have little opportunity to veto students' training despite unsatisfactory performance at house examinations. The only way students are 'weeded' out is through state examinations - the national failure rate for general state examinations standing at five per cent (May 1986). Students' practical work is assessed in the ward situation but in an informal way by the ward sister in the course of students' work performance. The proficiency assessment form is used to assess clinical performance (see appendix V1B). Keeping in mind how little interaction can take place between student and ward sister (Lelean 1973) and how students may even avoid interacting with the ward sister, one can question how valid such an informal assessment may be. Also ward and school may have different goals (one long term, one short term) in mind when assessing.

19. Normative control relies on the normative commitment of pupil and teacher; utilitarian relies on the promise of reward, e.g. payment, graduation, etc.; whilst coercive requires a control as in a total institution. Etzioni (1964) cited in Metz 1978.

20. Many students before applying for training 'knew the score' - as the accounts in chapter 4 indicate.

21. The student in her 3rd year who was demoted may have thought little could happen to her (see p.133), yet she found herself losing rank and being told 'don't apply to be kept on!'

22. Metz (1978, p.61) states that such "patterns depend upon the school's establishing a social definition of the situation that does not fit 'reality'. If the students accept the definition it is real for them and operates to control them. But it is nonetheless a fragile social fabrication requiring careful nurture by the adults."

23. The problem of 'pull' (see p.173) is a reflection of this.

24. Bernstein, (1971A, p.47) states "...evaluation defines what counts as a valid realization of this knowledge on the part of the taught."

CHAPTER 7

THE LIFE OF THE WARDS
A Hidden Curriculum of the Clinical Areas?

Introduction

Life in the wards has been well documented (Fretwell, 1982; Melia, 1981; Ogier, 1982; Orton, 1981; Pembrey, 1980). In this study, while a large amount of data was amassed on the experiences of ward life, the present chapter deals comparatively briefly with these experiences.

The structures of the clinical areas serve to transmit many messages to student nurses. This chapter focuses on the ward experience as it examines the role that is made available to the student nurse in the clinical setting. It must be considered in the light of the students' other experiences in the hospital training school (chs. 4, 5 and 6), as these 'set the scene' for her role in the clinical areas. This account is presented under the following headings: the hierarchical division of labour, the 'work ethic', learning and working, and uncertainty and ward life. Although dealt with separately, it will be seen that all of these aspects of ward experience are interrelated.

THE HIERARCHICAL DIVISION OF LABOUR

Perceptions of Hierarchy and the Division of Labour

As indicated in chapter 4, student nurses have some pre-knowledge of their place in the hospital hierarchical structure and on entry to training this is reinforced in the school of nursing (ch. 6). In the hospital, one's place in the hierarchy is visible to all. Rank and consequently status is signified in hospitals initially by dress, and/or insignia and as

I shall indicate by spatial location and interaction network. Spatial distancing is apparent on wards (1). Regarding her presence in the nurses' station. Rachel Corrigan says:

> "There is one ward where we were told that it wasn't our place to be in the office as such."

While Deirdre Kane says:

> "Somebody might want a drug and it may be in between the actual drug rounds and you might have to find someone and go and check it with them and get it ordered or get things written up...that is the only reason you would want to go into the station - its really in and out!"

Certain areas of wards are 'no-go' areas for students i.e. sisters' office or the nurses' station. This is apparent from observation and students recount feeling uncomfortable and 'out-of-place' there. By way of illustrating her reality, Helen Cox explains that if staff nurse and sister are in the office that rather than approach them both together, she would, slow down drips even if it meant medication running late, so that she could put off approaching them and interrupting. This distancing and the hierarchical arrangements are very real for students and they report feeling very much 'in awe' of those senior to them. This was corroborated by some trained staff who felt students 'held back'. Students complain about the hierarchical structure yet hierarchy and differentiation are apparent in the language both students and staff nurses use. For example Anne Walsh, a 2nd year student in St. George's, writes in her diary of a night shift:

> 3.30 a.m. "sent junior nurse to cofffee break for 30 mins...
> 6.00 a.m. As senior student I did the drug round with staff nurses, and two junior nurses do the 6.00 a.m. checks, diabetic urinalysis and glucomate checks."

The very existence of hierarchy presents the possibility of the reward of upward mobility (2). Moving up the hierarchy, whilst being desired, may be feared; Rosemary Armstrong, describes how she felt when she got her 2nd year strip and her apprehension of the difference getting her 3rd year stripe will make to her 'responsibilities', as she will have more juniors

under her and is expected to answer their questions. Rachel Corrigan in her 2nd year explains how she feels about becoming a 3rd year.:

> "I really am scared of going on, the higher up I get, the worse it is...The third year is in charge, if its a big surgical ward there will be one staff nurse and she'll usually be linked with another ward as well, so she <the third year> is really responsible for everything - the staff nurse is on her breaks a lot of the time and she's over checking the drugs on another ward so you are left an awful lot on your own with maybe only a second year and a first year under you who are depending totally on you."

Carmel Macken describes her experience of receiving her six month band (3):

C.M. "I remember when I was getting my band and it was drummed into us that people would expect an awful lot more of us now.

M.T. Who was saying this to you?

C.M. Matron when she was giving us our band - you know things will be expected of you now that we will have more responsibility on our shoulders. I came out being absolutely scared."

Some experience a difference in the way others, even students, respond to them as they move up in rank; Sarah Evans says:

> "There is definitely a division and I think I only noticed it a lot when we became second years and maybe you would meet a P.T.S. and she would say 'you are a second year'...I mean you knew that they were kind of taking you on a different level from what they were taking their friends."

Students describe the difference a rise in status makes. Angela O'Neill explains what it's like to have any kind of rank within the hospital:

> "Once you have a band of any description that helps you...When we changed from a green to a brown band, I was on an evening shift and the brown bands weren't being given until four o'clock and you went on duty at twenty to three, so I went on duty with the green band, and I went off for ten minutes to get the brown band and there was a difference. A total absolute difference - doctors coming up in the lift talked to me, one of them was a registrar, and he said there is something very different about you today, and then he looked and saw the band and said I was getting very cocky."

It seems that in these hierarchical structures, students find that one's rank is the most important fact and it is one's rank, that is responded to, and not one's personal self.

Within the hierarchical nursing structures, students recognise work

as being of higher or lower status. Paula Jennings recounted to me with some astonishment the 3rd year student who sterilized the bedpans every morning (4, 5, 6). On high and low status work Helen Cox said:

> "In 1st year you get the rotten jobs. They might give you the horrible jobs...emptying bedpans..."

Susan Reid stated that her impression of staff nurses' work was quite different:

> "They don't have to do dirty work...bedpans...they are not really what I thought a nurse would be."

Students recognise that promotion and higher status means less involvement in direct patient care. They perceive that those who have higher status do not provide direct patient care. A third year student nurse describes how 'distant' some ward sisters become because of the hierarchical division of labour. Deirdre Kane says that some ward sisters are good:

D.K. "...it varies...one ward I worked on and the sister never put her hand to a patient literally, for a bandage, dressing, an injection or even a tablet.

M.T. How did she know what was going on then?

D.K. She would just come and ask you or a staff nurse or she would say 'call me' and she would come down and have a look while you were doing it and that would be it!...and then she would be gone. Invariably patients ask 'who was the lady in blue' they just didn't have a clue. But then on another ward, the sister is very good and will make it her business to see everyone's dressing, either assist or do it herself or if the students are busy with other things, she will make a point of doing it."

Mary Charlton in St. Robert's, discusses some of the implications of the division of labour for care as she indicates who has most patient contact:

> "1st years...and maybe a bit into 2nd but definitely 1st years because when you're in 3rd year you <could be> left at some stage in charge of the ward and in that way then you just have to take over the clerical side..."

It is student nurses in the lower ranks who provide direct patient care. This is their work and they are expected to get on with it. Movement up the hierarchy means movement into 'clerical' work and away from patients. Students see getting a new belt, or band as symbolic of their rise in status, almost as an acknowledgement of their own self-worth.

Perceptions of Hierarchy and Medical Dominance

Within the clinical setting, student nurses perceive the authority of the doctor. Eimear Long says:

E.L. "Medicine is on a pedestal as opposed to nursing and the status and everything! Doctors get so much respect, their status is fabulous. They deserve a certain amount of it! Nurses on the other hand, are sort of treated very much inferior in the ward set-up.

M.T. What would make you say that?

E.L. Well, I mean...maybe I should say that the doctor treats the nurse very much as a sort of somebody who, well I mean somebody who carries out their orders, that is true, but I don't think that the right respect is given to nurses. I don't think that they are treated as individuals as much as they should be..."

She continues, perhaps indicating what was behind her initial statement?

"...say from an onlookers point of view, the attitudes towards nurses, of doctors towards nurses leaves a lot to be desired! Definitely towards the student nurses, there isn't very much communication, if there is any communication which there is, it's usually staff nurse-doctor."

Thus, indicating how rarely interaction takes place between student nurse and doctor.

As suggested (ch. 4), nursing enhances its own status through its close association with medicine. Nursing specialties can be seen to closely follow medical specialties and in medicine, those more esoteric specialties, (i.e. nuerological surgery), receive most status, those involved in public health and preventive medicine, radiologists and pathologists receive less (Stevens, 1971). Some accounts suggest that student nurses identified more so with medicine than with nursing. Ursula Dwyer in talking about the nursing process indicates that she sees little difference in or need for a nursing history as opposed to a medical history:

"Like its supposed to be that you ask the patient with no sort of propping up from the doctor's notes...the way it ends up a lot of the time over there is that you see what the doctors have to say first and you just write the same down."

This student sees no difference between a medical and nursing history. The

result is that nurses can over identify with higher status medicine. In some cases the 'technical' aspects of nursing appear more highly valued than basic nursing care. For example, Sister Whyte (7) complains, as tutors do, about nurses' concentration on technical aspects of care; she describes what she means:

> "...you often notice and I have come across it lately a lot if you ask a nurse about a patient that is going to theatre...they tell you...oh! yes consent signed, duly put away...they have forgotten about the bath...they have their priorities wrong, the bath should be first."

In this hospital, getting the consent form signed is a medical responsibility. Conversely, student nurses feel that ward staff may have their priorities wrong in gearing all a morning's work to a doctor's round (see p. 232). Sister Whyte suggests that the school of nursing might be at fault in promoting a one dimensional view of the nature of hospital work. She says that student nurses seem unaware of the social worker in the hospital, yet, she herself expresses ignorance of a single occupational therapist in the hospital. She states: "You know things like an occupational therapist...I don't know an occupational therapist in the hospital...<yet>...there is". Angela O'Neill feels the same, she notes:

> "I just wish there was more unity between us, working as a team. You get lectures from the sociologist and the dieticians and they will all admit it, they'll all say, we can't do anything on our own, we depend on you so much for information. I feel that they really mean that and they do act like that too. They will come up to you and ask and they are so nice about it. They treat you with respect as if you know something. Why can't they all be like that? Why couldn't a doctor come down and ask you for an opinion on your level and the same with sister? You very seldom see a sister come down and ask you 'what you think'?..."

What appears to happen is that the message picked up in the hospital is that the only professionals with whom nurses work who really matter in the hospital are the medical staff. Consequently, nurses confine themselves to operating within the medical model and identifying with medicine.

Student nurses find that they are almost totally excluded from

interaction with medical staff. Doctors do not usually initiate conversations with students. I did observe a 3rd year finalist assisting a doctor with an intravenous infusion, at the instruction of the staff nurse, but interaction with doctors was clearly seen as something that was reserved for the more senior students and usually trained nursing staff. Sheila McCann states: "Doctors don't ask students questions, they never go to students..." Doctors rounds were unhesitatingly classified as staff nurses' work by every nurse I talked to, both trained and untrained. That doctors' rounds are considered important is illustrated when students point out how the work of the shift could become geared not to patients' needs but to the round. Sarah Evans describes the scene of the ward round:

> "They would conflab outside the door and then they go in. If you are doing a bed-bath or whatever and they come in...well some consultants would expect you to leave, some wouldn't. I mean you really wonder who comes first - the patient or the consultant."

The following arose from a discussion of being present in a ward at the time of a doctor's round, it makes a similar point. Margaret Nally speaks:

> "Even when rounds were on everything had to be quiet and that. There was no such thing of coming in and doing something else with the patient as the room had to be quiet and everything had to stop in that particular room. I remember once I was taking someone for a bath and they were away having the bath with me while the professor was going around and Ijust got her back in time. Actually he had got to the next bed but they went back to her bed I was told...never again like...have her there in time."

Their non-attendance at doctors' rounds, even as observers, is further evidence to students of their own low status. As the last account illustrates, in some cases, students' nursing work must become 'invisible' for the duration of the round. Students appreciate it when they feel they are treated with respect - a number of students mentioned the difference it made in the intensive care unit when they were 'with patients all the time, even when doctors were present and doctors treated you like a staff nurse.' The other occasion it happens is on the geriatric ward but as students point out, they are present on such occasions to help patients, yet it is appreciated and adds to students' esteem as they feel they are

not totally excluded. Generally doctors' rounds present occasions when distancing and demarcation become visible (8). This serves to reinforce the hierarchical division of labour.

Student nurses also suggest that nurses fail to assert themselves in interaction with doctors. Rosemary Armstrong speaks:

> "You see a patient and you know that if they are complaining of pains that they might not need a very strong analgesic, that probably all they require are two 'panadols', whereas you have got a doctor coming up on call who hasn't a clue who the patient is, who has never seen the patient, probably won't even see the patient then, but has to order up two tablets. The more I see that on night duty! More often than not the staff nurse tells the doctor what drug to order for that specific patient! But still it doesn't seem to sink in that they need nurses!"...I did actually see doctors asking staff nurses...'Well what particular dosage is the correct dosage for that?' because they might not have happened to have worked with that particular drug or whatever, but then again I still haven't seen any gradual change in doctors' attitudes towards nurses despite the fact that they will ask the staff nurse the dosage of such and such a drug. They still don't seem to be aware of the fact that nurses do actually know more than they are given credit for!..."

The following from Maria Carey, a staff nurse describes how unacknowledged, sometimes veiled, sometimes open recommendations are taken up and acted upon. I have asked if the physiotherapist sees every patient on the ward?

M.C. "No, she only sees the patients who the doctor would suggest would need to have physiotherapy pre-op or post-op.

M.T. So would you arrange that?

M.C. No, it is the doctors that arrange that.

M.T. So you don't have any direct contact with the physios then?

M.C. No, you see if we suggest say to the doctor that Mrs. O'Brien is chesty today and she needs some physio, he would write the form for the physio and give her the relevant details and the post-op, whatever operation she had and have chest physio or whatever we suggested...so you relate in that way, not consciously. As you see her you ask her how things are.

M.T. But you never have team meetings whereby everyone involved in the care of the patient discuss that patient?

M.C. You mean doctors, nurses, physios, social workers. No, it's just kind of in general.

The type of interaction suggested in the foregoing is very akin to Stein's

(1967) work on gamesmanship between doctors and nurses - the situation whereby nurses make subtle recommendations which doctors follow without acknowledgement. As Stein suggests what appears to happen is that nurses offer their recommendations in very subtle ways which consequently go unacknowledged (9). Therefore, as team meetings often fail to take place, the physician (not the nurse or the team) remains at the helm as all information goes to him and almost all instructions seem to emanate from him.

Despite their almost total exclusion from interaction with doctors and from doctors' rounds, students do nursing rounds with senior nurses i.e. nursing officers or matron. This reinforces the traditional hierarchical order of the hospital and conveys to student nurses their own low status. Student nurses find little opportunity for 'sheltered responsibility' i.e. to 'listen in' and learn on ward rounds, or pass on to doctors (in sister's presence) what they have observed about patients.

A number of consequences follow from this: Firstly, students are not allowed to interact with the higher status medical profession, their own status is too low for this; secondly they are excluded from some information relevant to their patients and work; thirdly they are excluded from a potential learning situation. Student nurses access to communication and information in the ward setting is now discussed.

Access to Information and Communication in the Ward Setting (10).

Another aspect of this hierarchical division of labour is the selective information to which student nurses may have access. This access to selective information emphasizes the student as a 'worker' who provides physical care, it serves also to reiterate the student's lack of status in the ward setting. It is to be expected that students acquire information about patients in the course of their working day but most especially at report sessions which take place at the commencement of each shift. Maria Fox describing a report session says:

"It's a very sketchy report and you barely get anything out of it...Each ward is like a separate unit so some wards you would be told everything that sister has been told but then on other wards they would have a cosy little chat with sister first to tell her."

The following response to my probing gives some indication of what happens at the morning report. Rachel Corrigan explains:

M.T. "Do you get the same report as the more senior students and the staff nurses get?

R.C. No, they get a little chit-chat in the outer office while we are all running around, if there is still a few to be fed, you might give a hand, the night staff don't always get the time and you have to wash the bedpans, set out the linen trolly and the back trolley so the staff nurses always get the nice little spicy bits of what happened during the night...we would go around and do all these little jobs, then we would go in and whereas we would just hear so and so had a restless night, the seniors would know exactly what they had been done and said, I remember one night there was a patient admitted and we heard after about two hours that she had been raped or something, and we weren't told that in the report...they said she had come for some investigation or something but it was never mentioned in report what had happened to her..."

Student nurses and staff nurses work different shift and this means that students come on duty in the morning before trained staff and receive a report from the night students. Once this is over, they are ready to get on with their work of bed-making, observations, etc. Staff nurses then receive a separate report. This has the effect of restricting information access for students, as staff nurses decide not to pass on information they consider irrelevant for them or at least not necessary for them to function on the wards (11). Ruth Kearns, a staff nurse said: "I don't believe in telling them everything at the beginning of a shift, after all, they are students." She felt that giving all instructions or information at the beginning of a shift, implied that there would be no further interaction between students and qualified staff and that that was wrong. From my observation interaction was minimal and because they are given restricted information students have less control over their work (12, 13).

Students wrote kardex reports on patients in one of the study hospitals but from accounts and observation of report sessions it is

apparent that an extra 'report' takes place for trained staff. Where students wrote kardex reports, these reports or students were not updated throughout the day and kardex reports consisted mainly of accounts of work done and any changes students might observe in, for example, the state of wounds. At report sessions delivered by students, sister or staff nurse might add an extra piece of information needed by students to function as workers, or correct misinformation in response to one of the occasional questions by student nurses. Sr. Peters agrees that omissions arise on occasions:

> "Usually what happens is maybe the students don't write in what they haven't heard or haven't written in whats happened on rounds, that's one of the major areas so maybe the patients have been seen by several consultants - that is usually one area that the staff kind of report on. That is usually written in the rounds book. Again social problems don't seem to be documented really."

From observation and interviews, it appears that a lot of the information collected by nurses is handled verbally and could therefore be classed as informal. Consider how Clare Smith, a staff nurse, catches up on patient information after days off:

C.S. "It's a verbal report.

M.T. When the staff nurses are going off and handing over to the next shift, that's also just verbal?

C.S. Yes, that's verbal also.

M.T. Say if you are off for a couple of days you can sit down and read the kardex but that won't maybe tell you some of the other bits and pieces, will it?

C.S. That's usually covered in the report that you get at the change over of the staff at that board - well each patient is talked about."

As indicated earlier students do not 'do' doctors' rounds. Being excluded from doctors' rounds also means that students are also excluded from information, lack of which can result in communication difficulties with patients, the following example makes this point. Ursula Dwyer explains:

"On the geriatric ward, if you're in charge of a room, and the doctor is doing his rounds in that room, you'd go around with him and all the team, so you hear everybody's point of view...I found that much better, because even if a patient did ask you a question you'd know fairly well what you were allowed to tell them."

Communication difficulties can arise with patients as students are sent to perform 'tasks' and have limited access to information (14, 15). Eimear Long speaks:

"I feel that on some wards, there's a complete breakdown of communication between what doctors say to staff nurses and what staff nurses say to the juniors about the patients, we had this woman down for a breast biopsy and I was told to go in and comfort her because she was very upset, that's all I was told, so I went on in and she was really upset and I said that it was a perfectly routine thing,that a lot of them are benign, so look at the positive side of it, you know, I didn't know that she had already been told that she had to have a mastectomy, that hers was not benign, and she had to tell me that then...it was a complete lack of communication, it was the staff nurse who had told me to go in and none of the students knew that hers wasn't benign, and here's me going in...she must have thought I was a complete fool..."

She notes that sufficient information is not always given at report. Rachel Corrigan says:

"They'll tell you in the morning to observe what X is eating but they won't tell why it is important - they never explain why or how you should go about it and you come back in the evening and you're asked what she ate and you say and that's that..."

Sister Whyte complains about students taking on too much, maybe talking to relatives and saying the 'wrong thing':

"Another thing that I often find about nurses too is...with relatives...some of them you know the relatives ask 'how is their mother' and they will tell them 'grand' and that they are looking after them and they have been eating and little things but then there is the odd nurse and the relative asks them 'what do you think are their prognosis nurse?' and say a first or second year will often gabble off and take it on themselves instead of sending them up to the nurse in charge. I don't know where they get this idea into their head that they can give information when they are specifically told in the classroom and in the wards and matron tells them not to. But they still do it...say enquiries on the phone etc., they take it on themselves to give all sorts of information...and then the relatives come in and say.:but we were told over the phone...and you really get yourself into a corner. We are lucky in this ward that we have a ward clerk and the ward clerk when she asks you early in the day about different patients and you give her the information about the ones that you

expect to be asked about."

The ward clerk is allowed to transmit messages to relatives but not so the student nurse.

Because of the way the hierarchical division of labour operates in these hospitals, two levels of information exist. Some of the staff nurses' information about patients remains at an informal or verbal level, which is not documented in permanent records because staff nurses do not write the report or because there is not an appropriate place to write it. This means that student nurses are unlikely to have access to the information. Information most likely to be passed on to students is medical in origin as it most directly relates to student nurses' workload (information from the social worker who attended all consultants' rounds was rarely passed on to students or documented in patients' records by nursing staff). The only information that students have access to with any certainty is the minimal information they need to function as a pair of hands e.g. whose dressing needs to be done, who needs an enema. Apart from the effects this may have on their work, it also emphasizes their place in the hierarchical order, a demarcation line between students and trained staff is highlighted because the 'cosy little chit-chat' and information generally is confined to trained staff.

Work Allocation

The hierarchical division of labour carries with it, a system of work allocation (task allocation on the basis of rank),it gives rise to a system of care which is task orientated. As implied in earlier accounts of hierarchy, a clearly defined hierarchical division of labour exists. Some wards had work allocation books, while from accounts of trained staff and students, work lists for different grades are easily compiled (see appendix V11B). Sr. Whyte describes how she allocates work on her ward:

> "We have the 1st years on say, the mixtures, utility room and sluice, tidying wards. Then they have other jobs that they do with the more senior nurses - the bed-baths which takes two,

dressings. Admitting a patient, they are on their own."

Although all the wards use some type of work allocation book; additional work not catered for within the ward routine is allocated at report sessions at the commencement of each shift (16). At report, students take note of work to be done. At a report given by Staff Nurse Ward one of the students I sat near made notes as follows: "Mr. Smith: 30 ml./water/hour. Staff Nurse Ward asked a 1st year to do a moutwash on Mr. Jones. Another student wrote: "Mr. Jones: Drip to be kept open". Staff Nurse Ward issued other specific instructions to all present, she stated "nothing is to go to I.C.U. with Mr. Murphy except his towel, no clothes.." On another occasion a 2nd year student was reading her report of the morning shift. Sister Bush interrupted to ask "Did he have a simple enema?" Mary Kiely, the 3rd year who was reading the report replied "No". Sister Bush reiterated, "He must have it this evening, the doctor said..." At the end of the report, Sister Bush reminded all present that the hospital was 'on call', mentioned the bed state and concluded stating regarding the enema: "It must be done...if he <the consultant> comes and it is not...all hell...he must have it whether he wants it or not." Very specific instructions regarding work are given only where absolutely necessary, otherwise reports tend to be a run-through of care given by the outgoing shift, that is, of work done. The work reported on, is always of the 'physical, doing' variety, other time spent with patients is not justifiable in terms of 'work'. Also on the larger wards the report session delivered by students was the opportunity for senior staff (sister etc.) who would have had little patient contact for the morning to get up-to-date information on patients - information that was again related to task performance.

As student nurses start work on wards, they discover that a designated work role awaits them in a ward's system of work allocation. This role may vary from ward to ward, but at a general level students provide most direct patient care and have most patient contact. The 'work ethic' is now discussed.

THE WORK ETHIC (17)

As indicated (p. 229), the hierarchical division of labour and the mode of work allocation has implications for who provides direct patient care and has most patient contact; as it 'maps out' roles, it reinforces the student nurses' role and the 'work ethic' of the hospital training school. Patricia O'Brien describes how she sees her role:

> "If something happens a patient, it's generally the student's fault because it is students that are mainly on the ward, the senior staff are in the office, so if anything happens it is your fault."

Maria Fox reports:

> "...everything that has to be done to look after the patients is assigned to the students except bed-baths and then the staff nurses help with those and drugs but everything else is done by the students."

Angela O'Neill points out the effects for her of this emphasis on her role in one area of the hospital i.e. theatre:

> "...you are sent to theatre to learn but in actual fact you are sent to theatre to clean because you clean the complete theatre and they say its good for learning. You see the technique - I was in theatre for eight weeks, and granted I did see quite a bit as I cleaned around the place but then you have med. students coming in...and then everyone is telling him what this is and what that is and you have been standing there all this time...and they are students, same as you, and I really think you are supposed to learn...they should be a bit more aware that you are not just there to clean up. Nobody minds cleaning up as long as you learn something in the meantime. Without the students, I don't think the wards would run at all."

Working predominates in a students' life (even when they're in the classroom, as I have indicated in ch. 6). Maria Fox describes the contradiction:

> "I leave here at 6 o'clock in the evening and do a three hour written paper and then get up and go to work. To me, when I was in college when you did exams and when they were over you could relax but now it's straight on to work. Some days it's a full day's work and a full day's study."

On the wards she says: "We are more like workers." The above accounts suggest an emphasis on students 'worker' role. The following account

summarises the 'work ethic'. Angela O'Neill speaks:

> "On some wards you just go to work at 7.30 a.m. and do all your work and you would just say "hello". You couldn't sit down and have a talk because you are supposed to be working and you have to look busy and then in other wards nobody would jump down your throat if you were sitting down with patients so you can sit down and talk to them...some people tell you - don't be standing around -sister won't like it."

Thus, students learn the hospital's expectation of their 'worker' role and the mode of its performance.

The Ward Routine (18)

The work ethic of the ward is transmitted to students in the form of ward priorities reflected in work allocation (see p. 238) and the ward routine (19). Fretwell (1982, p. 21) notes: "The routine is a form of communication between the sister and her subordinates since it encompasses her priorities and rules." Through the ward routine with its emphasis on particular aspects of care, student nurses learn that their role is to provide 'physical' aspects of nursing care. The importance of the routine is apparent as student nurses seek to find 'something to do'. They consider themselves 'settled in' on a ward only when they know the routine, that is, what to do next? e.g. dressings, bed-baths. From accounts it appears that the ward routine becomes very important to the student, as she changes ward every couple of months it becomes her anchor. In her interview, Mary Connolly, just a few weeks out of P.T.S. states:

> "I know the ward routine now, I'm happier but I still check with the third year first...I feel much more relaxed on the ward now...Before, if someone called you, you'd just do that, now you would not have as much time to be walking around, you know what has to be done so you just do it."

It is as though student nurses seek security and protection in the ward routine. Many report feeling uneasy and over anxious on new wards, until they get to know the routine.

Trained staff also consider the ward routine important. Sister Whyte suggests that interference with routine slows down work and ward teaching.

We are discussing how 3rd year students often have received little practice in the work they are expected to perform as staff nurses, she continues:

> "Actually some evenings I do the allocations for the next morning so that the minute the report is over we get down to work straight away but some days...It's great having it done the evening before. What really slows down work...patients have a fancy habit of dying in the middle of the time that you are busy...meal times or something like that, just before you are going off duty...I don't know why but they always do and of course there is a lot involved there...you have relations if they are not already in you have to ring them...you have the matron, we always ring the front hall here in case there are enquiries, then the laying-out of the patient and getting the porters to remove the remains, doctors who have seen the patients beforehand; but that was not geared you see in the evening duty and someone might have been allocated to do something else at that particular time..."

This account indicates the prominence attached to the ward routine, in some cases it may dictate the level of care, as work arising outside of the routine is considered unimportant, or an unnecessary interference.

It seems that nurses (and especially 'transient' student nurses), come to depend on the routine. This immersion in the routine, results in less interpersonal contact with patients, depersonalisation of patients and nurses and Cassee (1975) suggests, denial of, and detachment from emotional stress caused by relationships with patients (20). In this present study, students' accounts suggest four aspects of this 'work ethic'; i.e. 'working alone', 'getting through the work', 'keeping busy', and 'talking isn't nursing work'.

Working Alone

An observed feature of all nurses work (trained and untrained), was that of working alone. Students work in isolation from each other in a very hierarchical structure, distanced most especially from trained staff. To work with someone else when it is not absolutely necessary, is equivalent to time-wasting and breaking the work ethic of the ward and hospital life. This is so predominant that it features even when working alone is unjustified in terms of work to be done and workload. From observation it was apparent that when two students work together they often

split up the work so that they work in isolation from each other, e.g. the following occurred frequently: "Two students are working 'together' doing observations, the senior does blood pressures and other observations leaving the junior to do temperature, pulse and respiration. They start at opposite ends of the ward so that they are not with the same patient together" (observational records, St. Paul's). This working alone means that after work is allocated for the shift, students can be left and indeed strive to get on with their work without questionning, or the reassurance or support, of trained staff. Maria Fox explains:

> "There were three of us on one side on a very busy night in a surgical ward and there was another girl out of my class - we were both P.T.S.'s - we didn't even have a band and the staff nurse did nothing to help us all the time."

Annette Elliot describes her experiences on leaving P.T.S.:

> "You would be with a 3rd year looking after two or three rooms or whatever but after a while you would be expected to look after them on your own..."

Being with a 3rd year does not mean that students worked together at a task, but, as indicated in the earlier description, although both students were allocated to the same patients - within this allocation, they further sub-divided their work. Students were prepared very early in training for working alone, although they constantly 'checked' with each other. The following describes the beginning of 'working alone' or as students call it - responsibility; Rosemary Armstrong explains:

> "...you have probably had four months experience in the wards, and at that stage you are expected to use your initiative to go off and do things quite a lot on your own, you are expected to know a fair bit more...But then when you get your 1st band - you're really not a P.T.S. anymore and its 'I really shouldn't have to explain this to you as many times...you should be able to go off and do this yourself'"

Thus, very early in training, students discover that ward staff expect them to be able to take responsibility and get on with <u>their</u> work.

Students find that almost immediately they are responsible for ward

work a certain level of competence is expected of them. They do not always receive the necessary supervision. The school attempts to treat students as learners, while it seems, the ward staff cannot, they have other priorities. In relation to students working alone, Sr. Peters says:

> "I think in a lot of cases they do them very much on their own...they do procedures that shold be done by two, by one, in a lot of cases...I mean the bed-bath is supposedly a two person job...a dressing...Even the very simple things like stripping the bed. Ideally if you could have two students - they have been allocated rooms but they are not given a chance to stay in the rooms and this is not the students fault...it's the staff's fault. They are asked to do other things - I mean fair enough - that has to happen - if you had two students to allocate to a room or a student and a staff nurse to allocate to a room - ideally what they should be allowed to do is to go in, make the bed, doing the basic nursing care in those two rooms and not be expected to go down the corridor and do bed-baths but this is what is happening and not just there but all over the house."

This sister recognises that the reality for most students, most of the time, is that they have no control over work and even when work is allocated (i.e. room, patient or task allocation), the possibility is very high that they will be given other jobs to do. Carmel Macken describes how students get pulled from all sides when doing ward work:

C.M. "...but I often found that the staff nurse would be doing drug rounds or dressings or things like that, you wouldn't be involved in because you were so junior and sometimes they used to take you on a drug round and the senior would be kind of telling you to go one way and somebody else would be saying 'no - you have to do the drug round with me' and she would be waiting to try and do her report and you were torn between both. They would forget that someone else had told you to do something as well."

M.T. A senior would be?

C.M. A 3rd year."

Accounts in this study also indicate how students use their initiative in providing care. I suggest that the following from (observational records) is fairly typical and is well supported by other incidents: "A student nurse approached Staff Nurse O'Rourke and asked her for Pethidine for a patient - without going to see the patient, Staff Nurse O'Rourke checked the Pethidine at the drug cupboard. She did not go to the bedside

to check that the injection was given or attempt to assess the patient herself." It is entirely up to the student whether this patient gets an analgesic (further illustrations of 'working alone' and the way in this this occurs are included in appendix V11, items C and D). It seems that the nursing care is only as good as students' initiative. I suggest that because of the emphasis on getting through their work load (discussed below), students find it necessary, not to wait for assistance, but rather 'get on with the work alone'. This causes further fragmentation of work, and is reflective of the student nurses' lack of power in the organization; it confirms her powerlessness.

'Getting Through the Work'

An extension of the emphasis on the student's worker role is the emphasis on 'getting through the work'. Rachel Corrigan indicates how routine and 'getting through the work' predominates even when commonsense deems it should not. She continues:

> "...like they have Mass for the patients every Sunday morning which is lovely, but Mass is from eleven to twelve but still all the patients have to be washed, sitting out smiling for Mass at 11.00 whereas you would usually have it done for 12.00 so you have to be done an hour earlier, no matter what you have to do. I often feel like asking them - 'do you want them to pray today or do you want them to be washed?'...don't ask for everything together, just lay off today and let them have the benefit of the Mass, they'll get washed this evening...why not take it easy and say 'do as many as you can before Mass and take it over after that'."

Though not necessarily their fault, students feel it acutely if the suggestion is made that they are not getting the work done - Sheila McCann's response gives an indication of the way they feel. When discussing what makes a good day. She says:

> "If I do something and someone comes along, like a staff nurse or sister and says 'do that now' and I say 'I have it done' and I feel I have one up on them now you know!

M.T. So then what constitutes a bad day?

S.McC. I think again the senior staff...maybe if they are in bad form they will take it out on you...if you are very busy and I always find there is someone on the ward that maybe doesn't pull their

weight..., that is not fair."

The importance of 'getting through the work' is transmitted through the ward's emphasis on routine and the system of work allocation. Related to the importance attached to 'getting through the work' is the stress on 'keeping busy'.

'Keeping Busy' (21).

Even while still in P.T.S. and on the ward en masse from P.T.S. for one day only, students feel acutely 'having nothing to do', Ruth Sweeney says: "...it's terrible when we have nothing to do...". Because of the emphasis on 'getting the work done' and 'keeping busy' students themselves may be the ones who impose sanctions or give the sidelong glances at fellow students who take time to talk to patients. Ruth Armstrong reports:

> "...people do that, they just talk to the patients purely so that they won't have to do this, that and the other. I think that I would probably 'sus-out' first what she was doing, before I would say anything to her. If I thought that she was skipping work, I would definitely say something to her!"

Even sitting down with patients seems to contravene the work ethic. Sister Peters recognises the unusualness of nurses sitting down with patients even when feeding:

> "Another thing really...you never sit down. Well I know the tutor we had said you could sit down if you were feeding someone. I hate to go into a room and see a student standing to feed someone or help them with their lunch...I always say to them sit down but they say...we are not allowed. They are allowed to sit down."

But, in the hospital ward, sitting down is in some way synonymous with 'taking things easy' and avoiding 'getting on with the work'. Many students note how patients probably do need more time spent with them but indicate that the work must get done. The emphasis on 'keeping busy' and 'getting the work done' gives rise to another message, that is, 'talking isn't nursing work'.

'Talking isn't Nursing Work'

In this study, the idea that 'talking is not really nursing work' was

another message of the hidden curriculum that students very clearly received. This was transmitted as a result of the emphasis on the work-ethic which was mediated through the ward routine. The message communicated to student nurses was that nothing, including talking to patients, should come in the way of the routine.

Students are not too sure that it is really their job to talk to patients. When asked whether she had ever been allocated the job of talking to patients in the same way as bed-baths or dressings had been allocated, Eimear Long replies:

E.L. "No.

M.T. Not even when a patient has been particularly anxious prior to an operation or something like that?

E.L. No, because I think it is mostly a staff nurse that would do something like that."

This student nurse is not even sure - she <u>thinks</u> reassurance and talking is part of staff nurses' work; she rarely observes staff nurses' work close up, especially now she is in her 3rd year and expected to work even more on her own (22). Ruth Doyle reports:

> "I found on one or two wards that I have worked in, if you were very quiet and had nothing to do, you went and you found things to do because sister doesn't like you standing round doing nothing."

Students are not too sure that it really is their job to talk because sanctions can be imposed for spending time with patients. Joan Burke explains:

> "They don't really say anything, they might say you've got work to do...they just hint. If you've nothing else to do and you want to talk to a patient, its best to go and give that patient a drink..."

While Rachel Corrigan says:

> "I agree that the patients have to be talked to and you have to allow time, but you have to have your priorities right too...it is very frustrating if you are busy and someone is daddling over a patient, but in the long run, that girl might be giving better care to the patient. But the line has to be drawn between what is practical and what is good theory, the good theory is to stay and talk to the patient and the good practical is to get the work

done."

These accounts demonstrate the contradictions. They are taught about patients' needs in school, maybe its even mentioned on the ward but they are still expected to get all the practical work done! Generally, students feel that they need the pretext of providing some aspect of physical care for patients to justify the interaction to onlookers. In this study, few student nurses saw communicating with patients as a 'real' part of the nurse's work except when everything else was done, there was even the suggestion that as a practice it was frowned upon by the nursing hierarchy. On nurse-patient communication, one fact which emerged clearly was that no positive reward accrued for increasing nurse-patient interaction. The implications for patient care are suggested in the following. Rita Fitzgerald, on a teaching trip to the wards describes the type of gap that can exist in care as a result:

> "Another woman in the ward, who was having a mastectomy and she was elderly and she had a very excoriated breast, and she hadn't gone to the doctor, she just couldn't obviously deal with it...She told me she was having her breast off tomorrow, I said to her...'how do you feel about it? How do you feel about your operation, and do you feel well?' She was coughing and barking, and a chronic smoker, she sounded dreadful, and she had a cigarette in her mouth, and I said to her would she like to think about not smoking perhaps for the rest of the day? She said that some people had asked her, but she didn't feel that it made any difference at this stage. But by the time we were finished she wasn't going to smoke anyway...she seemed quite happy... We eventually got to the bathroom and in the middle of what I was doing she started crying, she just broke down, she fell to pieces, and she said 'I don't think I am going to come back after this tomorrow'. Her thing was she thought that she was going to die, she just thought that she wasn't going to get through the surgery, and again everybody in the ward got what I got initially, but you see when the nurses don't look for anything more! All it needed was time to be with her, I didn't say an awful lot."

This account indicates something of the consequences of the 'work ethic' for quality patient care and patient education.

The student nurse learned that the ward's expectation of her is that of a 'worker'. The hidden curriculum suggested to student nurses (as they are subjected to the subtle sanctions and rewards of the structure) that

'talking isn't nursing work', that the good nurse is the one who keeps on top of the routine and gets through the work. These messages are enforced and transmitted in a hierarchical structure which relies on routine working, with students highly motivated to be part of the structure. The emphasis on the 'work ethic' also means that students are not responded to as learners, or, as full and equal members of the ward team. I have already discussed the effect of this in relation to access to communication in the ward setting.

SUPERVISION AND THE HIERARCHICAL DIVISION OF LABOUR

One of the implications of this hierarchical division of labour is that little direct supervision of student's work takes place or conversely students have little opportunity to observe trained staff at work (23). The hierarchical division of labour makes it difficult for students to observe trained staff at work and means that supervision of their own work (while inspection is a possibility) is lacking (24). Trained staff simply 'check up' on students' work, supervision of work usually consisting of trained staff asking "has...been done?" and accounts suggest that students handled queries and problems among themselves (25). Trained staff realise this and depend on students reporting back to them. One of the criteria for being a 'bad student' is "someone who doesn't report back to you, who doesn't draw your attention to the higher temperature or blood pressure" (Sr. Bush). The ward's expectation of the student, is that of obedient, reliable worker and not as learner.

LEARNING AND WORKING

Learning by Trial and Error

As indicated earlier, students work very much on their own in the ward setting. Students' accounts indicate how, because they are the main ward workforce, they are often in the position of taking responsibility for ward work for which they are sometimes ill-prepared. Mary Charlton recounts her experience of 'learning on the job':

> "...you are not supposed to do nasogastrics until you're in 2nd year but I was in P.T.S. and I was doing it for the simple reason that the ward was crazy busy and we were understaffed and the usual complaints but after a few I would have given one to anyone...thats the way I learned anyway, trial and error although sometimes probably it isn't the way to do it..."

Ursula Dwyer describes her first night as a senior on night duty and the uncertainty of it all:

> "First night of senior night duty was on a specialised ward, the metabolic, and I had n't a clue about anything, and on my second night I had to do senior, and there was another girl on the ward who was a relief nurse, she had never worked on the ward, it was like the blind leading the blind so I hadn't a clue really what to do and then in the morning there were certain things like, I didn't know to put a twenty-four urine collection into a 'fridge' or the MSU's into a 'fridge' until the morning, so they were all out on the shelf and I didn't know where they kept the MSU cards, I'd found some of them on the desk so I'd presumed that was all, in fact there were about three others to get and sister found those so..."

Maire Cummins, a paediatric trained post-registration student, describes what happened to her:

> "...one of my first big things here was I was told to catherise this female patient, and I couldn't name the day I catherised a child - I did say that I hadn't done it before but that just went down the drain, the staff nurse just said, well you know the basics and she didn't come with me although she knew...I was worried about doing it, but to me I just said keep it as sterile as you can etc., and after that it was more a matter of luck really."

These accounts indicate that once they are allocated to a ward, work allocation to student nurses, takes place on the basis of their ranking (or

position in the hierarchy) on the ward duty roster, and not on the basis of their knowledge or experience (see p.253). Annette Elliott explains:

> "...some procedures that I haven't done yet. You are just expected to know them now and to do everything now. You just have to learn it. Most things I know how to do in theory but I haven't actually done them. I don't think its very fair really."

Where students work with trained staff, the work is done like all ward work as quickly as possible, no time here for the leisurely teaching during a drug round envisaged by Maire Cummins:

> "But my argument is why doesn't the sister let the student take out the medicine, measure it and give it to the patient - what good is it to see a sister take out such and such and say this is whatever and you give it to this patient? Instead of saying there is the drug card, you do it."

Regarding ward teaching Fiona D'Arcy says:

> "...in more cases, you get the attitude that you go in and do the work and never mind whats wrong with them...but I think that there are some sisters that will kind of give you a tutorial sort of thing when you're getting the half one report, well, not tutorial really, she will say probably the day before, right you're coming on at half one tomorrow...they put it more in a help way that well, if you don't know about it sure I'll look it up myself and I'll tell you, this kind of a way...more in a learning situation that they do here in the classroom."

Indicating perhaps that properly handled the ward would be a much more natural and relaxed learning environment than the school. Maire Cummins notes:

> "I can only speak for a very small minority of staff who I have worked with, generally they would teach you things if you ask them."

Some accounts suggest that students will be taught if and when they indicate their needs in this respect. However Maire Cummins, who states above, you are taught when you ask, got little response when she indicated her uncertainty with regard to catherization (p.250). Many students are also afraid to ask, Sr. Peters says:

> "I think a lot of people are afraid to ask and query...I think asking questions at ward level isn't encouraged a lot and I think that there are a lot of people to blame, not only the students themselves but the staff are to blame in a lot of cases. I remember doing it as a student myself...I asked questions at an

inopportune time and I was thrown a dirty look...my goodness like you didn't do things like that!"

The way in which student nurses learn, is discussed in the next section entitled 'peer group learning'.

Peer Group Learning

Apart from the distancing engendered by the hierarchical division of labour, many students do not ask questions of trained staff for fear of displaying their ignorance to potential assessors. Instead they learn from their peers (26, 27). Charmain, as portrayed by Atkinson and Delamont (1976) also appears in nursing (see p.273), as students consult each other in the course of their ward work peer group learning is the norm. My observational notes record not simply students working alone but students learning from other students; the following extract illustrates this point: I was in the treatment room on Hunter, a surgical ward with Elizabeth Brady (a 3rd year), she was doing dressings. While we were still in the treatment room, yet another student (a 2nd year) appeared and asked Elizabeth a question. This time it was about a dressing, Elizabeth explained the size of the dressing strip and how to apply it. Then, Kate Cairns (another 3rd year) came into the treatment room, she asked Elizabeth "Is Mr. Ryan's dressing to be done?" Elizabeth replied "I don't really know". Again Kate asked "Is he going home?" to which Elizabeth responded "I don't really know, there's nothing written down". As she finished talking and got back to the dressing she was doing, another 3rd year student appeared and asked "How do I use hydrogen peroxide for wound cleansing and are Mr. Morris' stitches due to come out?" Elizabeth replied, advising on the use of a mixture of hydrogen peroxide and water to the wound and said to "check with staff nurse or sister about his sutures because there's nothing written down".

From these accounts it appears that the quality of patient care is only as good as the students' work, and the advice, support and assistance

they offer each other. Sister Peters also pointed out that even if students ask questions they may not get answers, and she indicates that students are fearful of trained staff knowing 'what they don't know' and prefer to ask fellow students. Because of this, students find that as they get more senior, it gets more difficult to ask questions as 'they are supposed to know'. Elizabeth Brady explained to me that she had taken out sutures for the first time last week. I asked her:

M.T. "Were you alone?

E.B. Well, I was but I went and got someone and they looked at me as much to say...'why haven't you done this at this stage of training' as though it was my fault.

M.T. Was this is student?

E.B. No, it was a staff nurse, there weren't any students around."

Students are apprehensive that others will discover how little they know. Yet, they find they have to assume responsibility, that is, to be able to function as workers and carry out designated tasks on their own.

Ward Work and Learning

Once students reach a particular stage of training, they require a certain competence as trained ward staff assign work to them on the basis of their rank. Pamela McKeown (a tutor and ex-ward sister) recalls her own experience as a ward sister:

> ...I was in the ward one afternoon and had a hemi-glossectomy and this little nurse came up to relieve and she was wearing a uniform which would indicate that she was quite senior so I said there is the patient over there...he has had a hemi-glossectomy, that means he has had half his tongue removed for cancer, and he is fine now but I would ask you to look after his oral hygiene whereupon she got weak at the knees and said she couldn't possibly look after the man's oral hygiene. So I said, you're a 3rd year nurse, its not the first time you have done oral hygiene - the man really needs it, his mouth is dry so that all you have to do to make sure he is in a comfortable position - that he is not going to gag on his secretions and keep his mouth clean and the girl went off and I heard the following day that she was in the ward with a duodenal ulcer. I was reprimanded, and I said, the need as far as I was concerned was to have somebody look after the patient...I couldn't stay with him myself...I was trying to manage the ward. I did the best I could with the girl and because she was a senior nurse I assumed that she would be able to cope with this situation, which of course, she wasn't for

> physical and mental reasons but that taught me a good lesson. But there was nothing else I could do...I had asked for help and this was the help I got, I was kind of up against it. I quite appreciate that student's dilemma. I would have been exactly the same had I been that student myself. I would have been terrified out of my mind and I can remember being absolutely petrified as a student, being sent somewhere and trying to do something that I didn't really understand."

She highlights the ward as a sometimes frightening place for students but also emphasizes the priorities of ward staff. Joan Burke points out as many students did, that ward learning depended on your ability to question:

> "I would find that I learn very little on the ward, you would if you asked I suppose...a lot of the time you don't know what you don't know..."

Sr. Peters notes how students go about their work without learning. She states:

> "A normal KCL <potassium> is so easy to remember,...and neither a 2nd or 3rd year could tell me. They are two and a half years here putting KCL into drips and they don't know why they are doing it. I was stunned absolutely you know. I didn't say anything but I really felt for them but thats the problem."

It seems that students find that they can function without theory and continue among other things putting up intravenous fluids and adding potassium, without knowing why. Clinical tutors (who are simply not enough to go around), can 'soften' the difficult moments for many students (28, 29). Eimear Long recalls:

> "...my first major hurdle was definitely injections! I'm not very squeamish, but I thought that it would be one aspect that I would be extremely squeamish about. I thought that I could never stick a needle into somebody's skin! I thought that if I did, that I would probably hit some nerve and kill the patient! But there again, with a clinical tutor...I thought this is grand, I will be able to cope with a bit of supervision of course as well!"

However, the supervision is not always available and the hierarchical arrangements militate against students seeking it out.

Trained staff find little time for patient contact, or ward teaching. Sr. Bush indicates some of the difficulties the student faces in her role as 'learner' as she indicates the contact she might have with students in the course of a working day:

> "There is not a lot...between doctors' rounds and matrons' rounds and generally going round the patients themselves, there is not as much as you would like to. Now another drawback we have here is...we have no clinical teacher on this ward."

Sister Whyte notes the difficulty she herself has in simply keeping up with information changes on the wards. Despite these problems trained staff recognise students' learner role and may try to bear this in mind when allocating duties but Sr. Whyte recognises that in the urgency to get the work done, learning needs may be overlooked:

> "You often find that say someone has missed out on something as a result of that. We have them all warned you know when they come here that they have so many things they have to get done in this ward and whatever you do to remind us...say when you hear a lumber puncture being done...look for it to be done."

Nevertheless, ward work and the provision of patient care remains the ward sisters' and trained nurses' main and most urgent responsibility. Carmel Macken says that once you get a band (even a 1st year band), the 'work ethic' means that:

> "You can miss out on a lot of things because if you are very busy you are not inclined to ask and a lot of things can just slip by and you can miss out on a lot of opportunities."

Students suggest that once they get their first band they are supposed to 'know their way around' and at that stage, there is noticeably less emphasis on 'showing them things'.

Because of the emphasis on the 'work ethic' in the clinical setting, senior students may avoid potential learning situations. Nuala Ryan reports that 3rd years often resent her 'working with them and slowing them down' whereas P.T.S. nurses are always glad to see her:

> "I do find that particularly the 3rd years, when they're coming near their finals and you come to them and they have the pressure of the workload to get through, that I feel they are resentful about your coming to them..."

She suggests that those students do need her help and indicates that basic care is forgotten:

> "I find that they can get resentful of doing the very basic things if you ask them and they really don't know them, they've

> forgotten all their basic nursing, a lot of the time I find with them that from that point of view it can be difficult."

That senior students can experience this resentment is evident in their accounts; I suggest that the 'work ethic' is so pervasive and immediate that learning and indeed nursing theory gets relegated to the background. Mary Charlton, describes her experiences and the problems with theory and practice in the work setting:

> "In theory, say you are told not to do something but when you go out on the ward, you find yourself having to do it for the simple reason that maybe you don't have the piece of equipment that is necessary to carry out the procedure or that and as well that you just say 'ah' well I won't bother doing it..."

Rachel Corrigan says:

> "I think they are more towards caring there in the school they way they teach, everything is done pit-pat, according to the book. I'm sure they would love to see you doing all that but to come up and actually work with you and see how things are often done, I don't know would they be pleased with us at all."

Students recognise and learn to live with a distinction between the ward's and the school's approach to nursing. They find that the latter can be left to one side as 'only theory' and that much of their learning seems superfluous. Rosemary Armstrong says:

> "There are loads of things that you have to learn that you don't seem to use in the end...again you use so much other things that you don't learn."

Students while appreciating that tutors' teaching may relate to 'real' nursing and the right way to do things, find for a variety of reasons that this 'real' nursing is not practical or does not take place in the wards. I suggest that this is related very much to their 'worker' status on the ward and as they 'learn by experience' in that role. Students never seem to see 'real' learning as taking place in the school, data relating to this section is rife with accounts of "well I don't really know it...I've done it in school but never on the wards." Considering the extent of 'working alone' and 'supervision' of students' work, this has very real implications for student nurses' learning potential.

Within the clinical setting a competency in practical skills with little pressure to show the evidence of corresponding theoretical knowledge gives a student a false sense of security which can result in her not seeking out the knowledge and even rejecting or feeling devalued by attempts to help her acquire it. Lack of a learning environment on the wards for students further lowers their status as they find themselves, not simply doing the 'skivvy jobs' in a rigid hierarchy, but the very factor which might soften this experience, their treatment as and recognitition as students, is absent.

Preparation for the Staff Nurse Role

Simply in terms of ward work, students recognise deficiencies in their training as they realise that the ward work they do fails to prepare them for the staff nurse role. Eimear Long reports:

> "So basically you don't get an awful lot of experience about drugs and things, not an awful lot. Then you've got things like I.V. drugs, when one day you're student and you are just watching staff nurses, and you've never given one, and then you get your finals and you have to give them yourself. You are supposed to be able to automatically begin to do little things like that."

Maire Cummins lists the work that trained staff do, but that students do not:

> "To discharge a patient, make an outpatients appointment for them or to check a prescription, you are very rarely asked to check if there are x-ray charts there for rounds next morning, you don't order stores or stock or you don't order meals, - you can take the list of what they want but you don't order it...and then one day you'll be asked to do something and you are just expected to be able to do it whatever it is."

Trained staff concurred with students on this matter, suggesting that students now receive less practice at staff nurse work than when they themselves trained (30, 31). Sister Bush states the areas in which senior students fail to receive a training which would help to prepare them for the work undertaken by staff nurses, in so doing, she highlights some of the potential gaps in training:

> "Dealing with relatives I know it's very difficult. I know its difficult when students are given no...they are not supposed really to deal with relatives as such, it is supposed to be handed over so therefore, phone calls should be handed over unless told otherwise. And the other thing is, I think 3rd years should be given a little bit more responsibility and a little bit more of dealing with relatives and explaining to relatives because that is a shock as well to have to turn around and tell somebody something that you have never had to do before, that is a bit of a shock when you become a staff nurse. I think that it would help if they were given more responsibility for the last six months.

I suggest that the gap between the work of trained and untrained is never bridged because of the hierarchical work arrangements and the emphasis on the 'work ethic', as learning without questioning takes place in the school, so working without questioning continues in the ward. Structural arrangements in the school of nursing and the structure of care delivery in the wards permit this. Even if trained staff are willing and able to fill gaps in students' knowledge, students may never seek information from them. The rigid hierarchy and consequent fear of authority as evidenced in the earlier accounts in this chapter means that distancing exists between grades and most especially between trained and untrained. As indicated, students often do not seek clarification of their work (i.e. how to do dressings, remove sutures, etc.) from trained staff, but prefer to seek advice from fellow students.

Summary

Learning by experience and peer-group learning seems to be the norm as student are fearful of 'not knowing what they should', and as they are expected to assume worker responsibilities in the ward setting. Students find no real use or need for theory in the clinical setting and accounts indicate that they are not adequately prepared for the staff nurse role.

DEPERSONALIZATION AND THE HOSPITAL TRAINING SCHOOL

Within the hierarchical structure, accounts suggest that students

experience a depersonalization. Eimear Long reports:

> "I could walk into a station, a nurses' station and there could be two doctors in there and I would walk in and nobody would say anything, this is in general, and the staff nurse would be 'yapping' away to the doctors as though I didn't exist. The doctor might say...'pass that chart over there', so you just pass over the chart."

This lack of recognition or, as students see it respect, is not only forthcoming from doctors, it emanates also from nurses and contributes to loss of self-esteem. Consider the following example; Sarah Evans speaks:

> "I had a terrible experience in Outpatients and I was the only student nurse and I felt I was just there to fill a space - you spent your time going around from clinic to clinic relieving for breaks. If you were in the clinic, initially you were there to help out but you were there as an extra you know, someone if something was needed you could go and run for it! It used to annoy me when they never called me by my name and one day the sister who didn't even know my name but anyway when she asked me and said 'oh! I must start calling you by your name now' I thought oh! great. There was one nurse in particular and you would be even standing there and she would say 'we will let the student go to break'...that used to really bug me now."

She suggests it is not just confined to Outpatients but it makes a difference if you are responded to as an individual:

> "I think it is lovely to find someone interested enough to ask you...some just think...oh! god another new nurse that doesn't know the ward but just these little things do mean a lot."

Maria Fox observes:

> "There is also another thing, there are med. students on the wards. While they are med. students on the wards nobody pays any attention in the wide world to them, whether they are final med. students, second year med. students or whatever! They are a general nuisance, they are regarded as a general nuisance on the wards, I think anyway, maybe I'm wrong! But the next thing, literally a week later they get their internship, they are on the ward, and they are getting a massive amount of respect from ward sister, staff nurses and students.

As students observe the 'respect' that others receive, they are aware of how little consideration their personal selves receive. Angela O'Neill notes:

> "On the afternoon shift, you're supposed to be off at twenty to three and you don't get off until anything up to four o'clock and you all stay on...that's not counted as overtime, its just accepted...some of the staff nurses will say to you, 'are you not

> off yet girls?' and 'thank you very much' and it makes a difference...but others will never tell you to go, you could be there until half eleven and you still wouldn't have gone. Officially we are off at twenty to ten and after that the night staff come on at half nine because they want to be there for the report to start, but the staff nurses are supposed to cover the ward...but you don't get off until the actual night staff come out of report which could take anything up to an hour..."

And Margaret Nally notes:

> "Some girls had planned to get married and they had dates set and things like that and then they were told that post-grads didn't have the group holidays because post-grads come in from other hospitals, wedding plans had to be changed because there was no way there were going to be given their holidays even though they had gone months in advance to see would there be any chance and it would be only one and they would just say, no, sorry...it happened to two of the girls and they had to cancel their weddings."

In the hospital training school because interaction is rank orientated and not person orientated, students as low status individuals feel they are not treated with 'respect' and can experience a depersonalization. Worsley (1970) suggests that bureaucratic structures are less person-centred. Many features of bureaucratic organization are identifiable in accounts in this chapter, but these accounts must be considered in the light of experiences elsewhere in the hospital training school. Students' experiences of depersonalization do not simply arise in the context of bureaucratic ward structures. They are related to the wider context of training (chs. 5 and 6) and to the early days of training when students were told 'we've hundreds more to fill your places' (ch. 4). Students infer their own worth and status from these encounters and the way in which people interact with them. Aspects of these accounts indicate that student nurses experience powerlessness and uncertainty.

UNCERTAINTY AND POWERLESSNESS

I suggest that implied in many of the students' accounts presented in this study to date, are experiences of powerlessness and uncertainty.

These can be seen to arise as students struggle to cope in a sometimes stressful work setting and where they identify their own key role; it can be exacerbated by students' uncertainty regarding the basis of their ward assessment report. As indicated this assessment is entirely service based and somewhat ambiguous. Fiona D'Arcy recalls:

F.D. "...on the first ward I was very lucky...I was the only one that didn't get into trouble in the whole three months. They just all got into trouble for all silly things but it is very upsetting at the time so I didn't really feel I should be worried about the ward report but I naturally was...but this ward sister was known to just give standard ones to P.T.S.'s so none of us were really worried about the ward report but I naturally was...But on the second ward I went to - we were petrified of the ward sister so that constantly got on our nerves and what was she going to write about us because the first two reports you get are supposed to be in depth reports whereas the rest of them are just...

M.T. Was your second report O.K.?

F.D. It was fine but you do worry about things like that.

M.T. Did any of the girls get held up or did they all manage to get a good report?

F.D. One girl, very unfairly...well we felt it was unfair, she got a bad character report and she was called down to matron. To us, her of all people was so ridiculous...What they wrote was - they said she was very careless about her patients and she wasn't observant enough and none of us could understand why they would write that about her. It was ridiculous and she was brought down to matron and given out to about it and she was very upset."

Student are uncertain regarding the basis of assessment. This uncertainty is evident in the preceding and following accounts. Margaret Nally says:

"I remember working up on the gynae ward; there is a lot of leukaemics as well, I thought it was one of the best wards I ever worked on and I put everything into it and I really loved it there, I got on well with everybody and I felt I had learned a lot up there, its a great ward to nurse on especially the cancer end of the gynae, I felt you could give an awful lot to them. But when I came out at the end of it, I was disgusted with the ward report I got, I just felt like saying, you didn't even think about that...There were other wards where I just thought I got on okay, and I would do much better, so I wouldn't go by reports at all. If I was to judge my career and how its progressing by reports...

M.T. So you really don't know what ward staff are looking for?

M.N. No, not really."

Joan Burke, describes how she feels:

> "You have the fear all the time that if something goes wrong, you are going to be blamed because it's your room, but it's amazing every day you are expected to do something else...starting off in a new ward, you are just sick for the night before wondering will you get on with the staff, will you fit in, will you be doing things differently? Because they do things differently on every ward especially if it is a very different type of ward."

Students find that in this setting if they fail to 'measure up' they can be punished, examples can be made. In one interview, I was asked to switch the tape recorder off so that I could be told about an incident. The incident was a minor one, the student was reported to matron by the staff nurse involved who insisted she had been given an instruction which she failed to carry out, after an interview with matron, the punishment was immediate (32). The student found herself taken off nights because: "I was told I wasn't responsible enough to put on..." In this hierarchical setting, one could never be too sure that all is well in relations with members of the hierarchy; students report that the 'friendly' staff nurse who was a colleague on nights, reverts to being 'cool and distant' once back on days. Angela O'Neill explains:

> "On night duty, you can get very, very friendly with the staff nurses, but you could meet them again on day duty and you say, 'Hi, how are you doing and how did you get on on your week off?' and you get back, 'it was lovely, thank you'...very cool.

On night-duty, students and the reduced numbers of trained staff have to liaise more closely. They may also find themselves doing 'more senior' work.

Students realise that their place in the hierarchy and the 'seniority level' of tasks they perform is infinetly variable. The following illustrates this constant fluctuating status; as soon as they think they have moved up a bit, students find they are back to being 'down there'. Sarah Evans explains:

> "On nights, you've got to have the confidence and the intelligence to look after all these sick people, whereas you could be on night duty today, and tomorrow you go on day duty,

> and you're back to being a student and you're down there. Like if if you are on night duty and you go on a drug round, not D.D.A., but the ordinary drugs and you use your own initiative and you have the sense or the cop to give the right dosage to the right patient and check the armband yourself, you don't have to be told - and then the next day you go back on day duty and you do a drug round and the staff nurse says this is that, and you check it three times, you go over to the bedside and you check the armband, she checks the armband, you give the drug, you make sure the patient swallows it...that kind of thing, you don't really want that..."

It would appear that feelings of resentment are engendered in students, when they are treated as learners, perhaps this occurs because for much of the time they are accustomed to taking responsibility for their own work? The fluctuating status that they can experience (due to changes in a ward's staff allocation), apart from creating uncertainty for the student, serves to affirm her powerlessness as she sees herself under the total control of the institution. She can never say 'no, I'm not ready for that', if the institution demands, she is expected to perform as a junior, or as a senior. Students' uncertainty is also reinforced as they realise that within the hospital training school, seniority is no protection against uncertainty or powerlessness. Maria Fox recalls the following incident:

> "I remember doing rounds one day and she <the nursing officer> wanted to know was she <a patient> still on something or other and I said, she is...so she picked up the chart to check and it hadn't been signed in for the day before and she had got it alright because she was still on it so we went down and we met the ward sister and she gave out to the ward sister in front of me...I'll never forget how embarrassed I was, she was saying 'how this should never have happened and all this'... There is a lot of things like that which happen and you kind of wonder what is going on at all...I think myself...you should have more professionalism than to give out to somebody like that."

Most of all, student nurses find that they have no power and should they try to confront authority they are likely to be reminded of 'their place' (33). They count themselves lucky if they 'get-by' without 'hassle' (34). Maria Fox sums up the experience:

> "The second ward I worked on, I got into trouble through my inexperience and it wasn't all my fault, it was also the fault of the staff nurse and I was so inexperienced I just took all the blame, and I said 'it was all my fault and I was so sorry' and I was petrified because I had been going well and I was due my

report and then she watched me like a hawk all week long and I was scared and I hated going to work and I used to cry coming off. It was just with the tension you were crying about coming off...I was so frightened and you never know what has been said about you and it did pass off. It was just a mix-up.

Their powerlessness can be experienced more directly, Annette Elliott describes some areas where they've tried to change:

"For instance...its not fair on the patient. I mean they are washed, up, they have their urine samples, their blood pressure <done> gowns <on> and they are sitting there for hours and hours and whats even worse is that patients who aren't going down until the afternoon and they are not told and they have been fasting all the time. I mean they could have had a breakfast and then fast. These things we try to change. There is just nothing than can be done...It was as if... we will have a students-matron meeting and we will keep everyone happy but don't you dare try and change anything. I haven't heard of any motion being passed..."

Uncertainty is perpetuated because students are all the time 'learning to do' rather than know, as they cope with their work role, they constantly 'feel their way' and never feel secure. This uncertainty and feelings of powerlessness can have adverse effects on patient care. Consider the following account, it arose in the context of relations with trained staff. Angela O'Neill speaks:

"I can't remember ever having been told in P.T.S. that they were staff nurses and ward sisters and you were only students...it obviously didn't leave a mark on me if they did tell us but I definitely do try to keep out of the way not to make waves...

M.T. And even if you're in the right, to let something go?

A.O'N. Well, it has happened to me once or twice. I can't remember specific examples but I remember a couple of times...not so much she's right and I'm wrong but in 1st Year I think it was on the drug round where I took the drug from her even though I thought it wasn't the right drug or the right dosage...and all the way over to the patient's bedside I knew it was wrong and I just didn't have the nerve to say and then just before I gave it to the patient I turned around and I came back and I said - do you think that is the right drug? She looked at me as if I had four heads and re-checked it and it was wrong and she said 'obviously, you weren't paying attention, you just weren't paying attention to what I was doing' but I was so scared to contradict her."

Maire Cummins also describes the repercussions this has for work and learning:

"I was on night duty there before we came into block and a

> diabetic was having a fasting blood sugar done and we were doing the drugs that morning and she turned around and said to me, I'll give him his insulin, and I said no, we don't give him insulin, and that was it - she never said why; she wasn't prepared to question it any more and I don't think she honestly understood the association between a blood sugar and him being a diabetic and having insulin because nobody had actually said it."

But for this intervention, there could have been very serious consequences for this patient. It seems that once they have enough knowledge to function as a 'pair of hands' and know the ward routine, students find they can 'get by', and work as best they can without questioning.

The foregoing has obvious implications for ward learning. Questioning is usually not a feature of exchanges in the ward as directions are issued. Students are afraid to ask questions and perhaps expose their lack of knowledge. As well as the assessment system, the 'learning-by-experience' described in the previous sections adds to the student's uncertainty. The nature of interaction in the ward setting contributes to students' recognition of their own low status and adds little to their sense of well-being and confidence. They experience powerlessness, uncertainty and depersonalization in the hospital training school.

SUMMARY

This chapter indicates the hierarchical division of labour within student nurses' work setting. It illustrates the distancing and demarcation that exists between grades and the ways in which this limits communication and access to information in the ward. Within this hierarchical setting students' experience their own low-status work role and learn the 'work ethic' of the ward and hospital life. They perceive that lower ranks provide most patient care and have most patient contact. In relation to learning on the wards, accounts suggest the inadequacy of supervision and teaching as students report 'learning by trial and error', 'peer group learning' and the failure of training to prepare them for the

staff nurse role. Accounts suggest that students' experience a depersonalization as they feel their individual selves and needs are unrecognised within the institution. Within the foregoing context, as well as depersonalization students' experience uncertainty and powerlessness as they feel 'on trial' on wards, are 'learning by experience', and can exert little influence to bring about change.

DISCUSSION

This chapter presents students' accounts of what life is like on the wards. As indicated, other writers, notably Melia (1981), and Fretwell (1982) have reported similar features of ward life. Many issues are raised, most particularly what I describe as the 'bureaucratic' nature of work organization on the wards i.e. the hierarchical division of labour, task fragmentation and routine working. Fretwell noted the emphasis on routine working in nursing. She suggests that the ward routine communicates the ward sisters' priorities to the student nurse. In this present study accounts indicate that nurses concentrate on getting through the ward routine; a routine which is geared to the provision of physical nursing care. Clinical experience revolves around showing students the way of the ward and ensures that they become preoccupied with 'keeping busy' and 'getting through the work'. On the whole, as they have to get through the work on their own they rely heavily on the ward routine, and come to resent any interference with it. What is not facilitated by the ward routine is neglected and hence 'talking is not real nursing work'. Fretwell (1982) has also noted how routine controls as individuals are limited in their actions. Within the routine, work is fragemented on the basis of rank. Salaman (1979) sees any form of task fragementation as a form of control with decisions travelling all the time from the top downwards.

Bowles and Gintis (1976) suggest that the hierarchical division of labour along with fragmentation of tasks deny workers room for the use of their creative powers and must be seen primarily as an instrument of control. They write in relation to industrial workers in capitalist societies, but it does have some relevance here in discussing the effects of such hierarchical work arrangements on self-image. If work arrangements promote routine carrying out of tasks in a hierarchical structure, then workers encounter their own powerlessness in the course of their work; this applies not just to student nurses but also to trained staff. It is suggested that rather than this increasing the efficiency of the worker, it is likely to decrease it. In industry, Bowles and Gintis suggest that worker control is likely to result in greater efficiency and productivity. Fretwell indicates that nurses close their minds during routine work, she states: "the performer need not observe the object on which she performs, except insofar as required by the task" (Ibid. p. 113); this has direct implications for nursing the 'whole' patient.

I suggest that the system of work organization described in this chapter acts to control and depower student nurses in their work role. Data in this chapter suggests that what students learn on the wards as nursing, is a particular way of 'getting through the work' and not the theory of nursing texts, or of the classroom (35). This 'working on the job' becomes the students' reference point and not nursing theory. Nursing theory espouses an approach to practice that is patient centred and team located (36, 37) - but in nursing the socializing agency is far from homogenous and hence the number and variety of accounts which attest to theory-practice gaps (chs. 6 and 7). Gaps between theory and practice can be highlighted by considering the rhetoric of nursing theory (ch. 1) and the reality of clinical experience (ch. 7). A gap divides them as one focuses on producing a 'professional' nurse with a view to producing an 'autonomous' nurse, whilst the other has to focus on the much more short

term goal of delivering safe patient care - in the course of which some patients' needs may be ignored or forgotten (38, 39). Without sidetracking into a debate about the possibility of professionals in bureaucratic organizations experiencing conflict (Davies 1983), I suggest that theory-practice gaps may be conceptualized as bureaucratic versus professional approaches to nursing care. Davies (1983), and others, suggest that the modern hospital has not always been bureaucratic in nature and that therefore we should not analyse the hospital from a narrow concern of professionals and bureaucracies, but that we should set occupational development into a societal context and consider wider class and gender issues. Garmanikow's (1978) paper on nursing indicates the importance of this adumbration and it is one I heartily endorse. Nurses are attempting to present what they see as a professional model of care, their inability to impose this may be linked to their lack of power as an occupational group and as women. Chapter 6 indicates how nursing theory fails to make an impact on students in the classroom and chapter 7 shows how the immediacy of ward work dominates their 'working life' and how student nurses are controlled by bureaucratic features of work organization.

Burns and Stalker (1961) contrast 'mechanical' and 'organic' organization; 'mechanical' being similar to the bureaucratic mode whilst 'organic' is similar to professional authority where no hierarchy exists and power rests with the members of the profession. It is suggested that the organic model is more suited to coping with uncertainty and change, whilst the 'mechanistic' model relies on tasks being convertible into routine. Pembrey (1980, p.17) also discusses these management systems and questions the appropriateness of a mechanistic management model to nursing. Her study showed that the ward sister's ability to find a form of nursing organization sufficiently flexible to deal with the unstable ward environment, was one of the features of ward sisters' who organised care

"in relation to individual patients and individual nurses" (Ibid. p. 84). This present study indicates a rigid and inflexible system in the existing hierarchical division of labour in the hospitals studied. I suggest that bureaucratic or mechanistic type approaches to care are incompatible with individualized care and theories of nursing care. Davis (1980, p. 117) suggests that 19th century hospital based service training for nurses was a compromise given existing social and economic conditions - it follows that current practice is reflective of wider social relations (Ashley 1976) and that the cause of the problem does not lie within the individual psyche of nurses. From the accounts of powerlessness and lack of control evident in this study this would seem to be the case. The fact that nurses operate within and themselves perpetuate bureaucratic structures may be indicative of their relative lack of power. I am not contrasting professional and bureaucratic structures as such, but simply point out that individualized care is incompatible with aspects of bureaucratic organization i.e. the hierarchical division of labour and the routine working at ward level that is the norm in nursing (40). I now discuss the ward as a learning environment.

The Ward as a Learning Environment

I suggest that the ward fails to function as a learning environment for students. Fretwell (1982) indicates that a traditional model of nursing, with it's reliance on routine and task orientation, may not be conducive to learning, and in chapter 6, it was similarly suggested that a tension may exist between order and education (p. 220). The emphasis on the ward routine creates an environment where questioning seems superfluous, and teaching an unnecessary interference with ward work.

In this chapter, powerlessness is evident in the way student nurses learn on the wards, and this is now discussed in relation to 'trial and error' learning. In nursing, it is suggested that routine replaces supervision as a means of controlling an untrained labour force, yet,

supervision is an essential aspect of the ward as a learning environment (Fretwell, 1982). Student nurse training is likened to an apprenticeship system, but Fretwell (1982, pp.23-24) states:

> "Demonstration is essential in teaching skills, followed by practice under supervision to correct errors. Therefore, the supervisor must both see what is done and know what error has occurred. An apprenticeship training implies that the apprentice works with and is able to see the craftsman. The problem of control, therefore, has two dimensions - firstly that the apprentice should be observable to the craftsman, and secondly that the craftsman should be observable to the apprentice, for without such conditions skills cannot be learnt without risk of error. Supervision cannot be dispensed with if the ward is to be a 'learning environment'."

She notes that Gouldner (1954, p.160) found that "workers viewed close supervision as a kind of strictness and punishment" and that rules in place of supervision relieve tension, yet she indicates that Kendall (1963) found that house officers welcomed close supervision.

In this study, many students would have welcomed the opportunity to practice under the watchful eye of a trained member of staff. But 'peer group learning' and 'trial and error' learning is the norm and the 'checking up' that passes as supervision is almost resented by the senior students as it can add to their uncertainty and, by its rarity, imply incompetence. Consider Nuala Ryan's feelings about the attitudes of 3rd year students to her clinical teaching role (ch. 6). This occurs because the hierarchical context firstly militates against students feeling comfortable with this type of supervision or in seeking the help of trained staff and secondly because the work of trained staff is not observable by students. As accounts suggest students 'work alone' and rarely observe 'the master' at work. Some students are not too sure what work the staff nurses do. In this type of setting where some groups have control of their 'observability', as Gouldner indicates, supervision can be seen as punitive. Likewise use of space and other physical arrangements may contribute to 'observability'; with some groups (the less senior) confined

to more observable sections of the wards, and superordinate groups less observable as they occupy more private physical space. Rosengren and DeVault (1964) in their study of an obstetric unit note how more powerful groups may use physical space to insulate themselves from observability. As indicated (p.157), Coser (1961) has also discussed insulation from observability and types of social conformity and one aspect of observability i.e. the provision of control over status occupants. She indicates that certain structural requirements determine the extent of observability.

In this study, it is apparent that some groups had control over their observability, while student nurses had very little, this also is indicative of their powerlessness and was discussed earlier (ch. 5) in relation to access to 'frontstage' and 'backstage' areas. As it is elsewhere in the hospital training school, so it is in the wards, and student nurses find little access to 'backstage' space. Restrictions on the right to privacy and secrecy are indicators of the relative powerlessness of the student group, and contribute to keeping them 'in pipeline status' (see ch. 8). As Goffman (1971A) suggests any society can be profitably studied in terms of its stand-off arrangements, the hospital community proves no exception.

Learning and Clinical Experience

Nursing students do not simply learn in the classroom, they are also learning on the wards. This 'learning' is quite unlike the guided discovery learning described by Atkinson and Delamont (1976) as it gets spoilt first and foremost because student nurses are not permitted the security or luxury of playing games, their's is serious work caring for the sick and dying, and as indicated, it usually takes place beyond the supervision of the trained. With the experience of classroom science and 'cold' medicine, the teacher remains in control (Atkinson and Delamont). However, I suggest that in the clinical setting in nursing, this is not the

case, as tutors do not control encounters in the ward, or ward learning experiences. The fact that student nurses share responsibility for care in the work settting diminshes educators' influence and has other implications. Reeder and Mauksch (1979) point out that the influence of service workers on the novice results in a lack of complete control by educators over socialization. They state that service work results for the student in:

> "transfer of personal qualities, attitudes and demeanor to the nursing role, making them subject to the field's norms, rewards, and sanctions." (Ibid. p.216)

Wyatt (1978, p.274) found in his study that:

> "Nursing as a profession can be seen to be defined by the character and behaviour of the nurse rather than by her intellectual quality...throughout the nurse's career there is a system which is extremely well adapted to encouraging and reinforcing certain character traits. It might be argued that a system which encourages peer group learning, emphasizes hierarchical status and approves of normative character formation and behaviour is likely to be adaptive and not to be one which encourages individual self-directed study techniques."

Regardless of the educational role message (be it that of teacher, carer responding to individual needs etc.) it is unlikely to be influential unless it is congruent with the service setting. As Wyatt (1978) suggests the system is adaptive. It indicates that students cannot implement new knowledge or be agents of change. I discuss this further in chapter 8.

In nursing, the emphasis on ward experience and the milieu in which it takes place, greatly contributes to the disease focus of nursing and the student's identification with higher status medicine. This study supports Fretwell's suggestion that the structure of order in the ward supports the medical order. Atkinson (1979) noted how the bedside teaching of medical students included assumptions about disease. I suggest that apart from structural messages acquired in the school of nursing (ch. 6) nursing theory and education is also devalued in the clinical setting, as students find it taking second place, and as they 'learn by experience' and by

'trial and error'. Like Melia's (1981) students who questioned their need for nursing theory when they worked alongside auxilliaries who had none; students in this study felt that as school failed to prepare them for the real world of the wards, that much teaching was unrealistic and perhaps unnecessary. The whole emphasis became not on knowing but on doing. It is significant that students in this study, only felt they had learned something, when it was carried out in the wards on real patients. School learning is not seen as 'real' learning, yet, rarely do students get the opportunity to practice in the ward under supervision.

Ward and school staff have different priorities, so gaps may exist between tutors and ward staff on what agreed knowledge, or the students' role may be. Atkinson and Delamont indicate that 'cold' medicine can be seen to provide the grounds for 'extended educational encounters'. But they note what happens when such guided discovery goes wrong and the anxiety it creates for students. Mrs.Linnett's guided discovery classes achieved some success, but Dr. Cavendish left pupils to play at science. Atkinson and Delamont (1976, pp.95-96) note:

> "It produced a high degree of anxiety and confusion among the pupils, to the extent that observation was an embarrassing, even distressing occupation..throughout the field notes similar episodes - characterized by muddle, confusion and anxiety - are recorded...many of the lessons only 'worked' because of a pupil Charmain, who conducted tutorials at the back of the room using the textbook and her group's result."

I noted similar anxiety when student nurses were allocated ward and school work without appropriate guidance. In the wards, student nurses work a lot of the time under some type of 'guided' discovery conditions as they work and learn by 'trial and error'. 'Learning by experience' or learning by 'trial and error' is as accounts indicate commonplace in nurse training. I suggest that it is an expensive way to learn in terms of spent emotions and self-esteem. Whatever outward composure, a student has, soon disintegrates under such pressure as students' 'identity' and identity equipment (in terms of being an efficient 2nd or 3rd year) is lost, and the

mask slips. The system works, because students, like Atkinson's and Delamont's 'Charmain', help each other out. But it depowers and creates uncertainty for the student nurse.

This chapter also indicates that hospital wards may constitute stressful environments for student nurses as they are confronted with new 'hurdles' every day. It is within such a context that they are socialized as they worry about doing their work right, of giving their first injection, of dealing with an emergency, of coping with their first death and distressed relatives. This uncertainty may be exacerbated for students as degrees of uncertainty exist with regard to ward expectations (see pp. 260-261), the assessment system coming across to them as somewhat arbitrary. Students try to 'avoid notice and hassle'. Melia (1981) in her study of student nurses noted that the desire to 'fit in' was strong. She also found students only finding out what ward sisters expected in the course of their ward work and adapting accordingly (Ibid. p. 309). I suggest that as students experience uncertainty in this structure, they find that they can cope best by staying with the ward routine (41). In the case of nursing, Hillier (1983) suggests that conformity and routine is espoused at the expense of individualistic responses by both patients and nurses.

The accounts presented in this study to date suggest that student nurses do not experience the institution as 'person orientated', rather they are expected to 'fit-in' to the organization (see chs. 4, 5, 6 and 7). This results in depersonalization of both nurse and patient and can be associated with bureaucratic practices. I suggest that without the foregoing system of work organization in the wards, mistakes would be much more common, trained staff would have to be much more mindful of their student workforce and change in the staffing and structuring of work in clinical areas would be necessary. The system remains reasonably safe

because of the degree of control exerted; the system of task allocation, and students fear of making a mistake (a fear played upon and even inculcated by the hospital). Thus the precarious system of work for the student, remains in a very delicate balance 'safe' for patients; its safety depends on the student picking up the messages of the hidden curriculum.

Conclusion

To conclude, accounts indicate how the existing order is maintained in the hospital training school and the way in which student nurses are realised as 'safe' workers (chs. 4-7). As indicated (chs. 4 and 5), when student nurses commence training they are exposed to a form of total evaluation. They experience depowerment and loss of self-esteem as they are faced with hierarchical control of appearance and behaviour, and with surveillance. As they try to keep up with school work, they report at great length the 'pressures' of P.T.S. - a by-product of total evaluation and control. Within the classroom itself they acquire notions of what it's important for them to know and they pick up messages regarding the limits of their own role. The methods of teaching to which they are exposed confirm their own low status, as they realise that it is considered, they have nothing to contribute and are simply to be passive recipients of knowledge transmitted. Students' powerlessness and inability to control encounters is apparent in the school of nursing, this can be seen to emanate from the way in which knowledge is structured and presented. This chapter also indicated the way in which student nurses are controlled within the system of work organization on the wards.

Chapter 7, stands in almost stark contrast to chapter 6, where a theoretical framework for analysis was clearly evident. At the end of the day I could only be true to my intention to 'let the data tell the story' while relating the findings to other work in related areas. The differences between chapters 6 and 7 might simply be highlighted in stating

that one deals with the life of school whilst the other deals with the life of work and the ward. Chapter 6 draws on a structural analysis from the sociology of education while work in medical sociology helps to analyse and locate data in chapters 4, 5 and 7. This is a reflection of the open theoretical approach adopted in the study (see ch. 2, p. 57), no one theoretical framework presented, which would bring together all the data in the study and take account of the theoretical concerns outlined in chapter 2. The next chapter attempts to bring together data presented in the preceding chapters.

Data chapters to date, have indicated control as a major feature of the hospital training school (42). Neither on wards, in school of nursing or in the nurses' home, do students' experience release from this control. In the school of nursing, they are controlled by the structuring, ordering and presentation of knowledge, in the ward by the bureaucratic mode of work organization. They are the subject of wider control as they find overlap between ward life and school life; between private and public selves and experience aspects of life normally associated with total institutions. In the course of training I suggest that they experience depersonalization, uncertainty and powerlessness. I put forward the concept of 'pipeline status' to conceptualise the experiences of student nurses in this context and this is presented and discussed in the next chapter.

FOOTNOTES

1. As indicated (ch. 5), it also extends to other areas of the hospital.
2. As indicated in chapters 5 and 6, downward mobility is a possibility and fear of downward mobility is as present as apprehension of upward mobility.
3. Matron pins on each student's band. These symbols represent rites of passage in the institution and are very important to students.

4. In different hospitals, students were allocated different work even though at the same stage of training i.e. not all P.T.S. nurses gave injections, rather students gain practice in and learn whatever work role the organization demands (see work allocation p.238).

5. Within this hierarchical division of labour in the normal course of events, students can experience some fluctuation as their work role fluctuates according to the ward's requirements (see p.262).

6. The student's role is discussed later in this chapter (pp.238-242).

7. In the course of interviews and ward observation, relations with sisters were formal and the formal title above reflects levels of distance.

8. During my time in the wards, I observed only one student start a round with a doctor. It happened because one staff nurse was at lunch and the other was delivering the report to the oncoming shift. However, when the staff nurse returned from lunch she was sent to take over from the student - this was the only such occasion observed and its rarity was supported by interview data.

9. Nurses are so aware of their 'low status' that they fail to exercise the power available to them. They make no attempt as subordinates to control when as Mechanic (1968) points out they could. Consider the accounts of doctor-nurse interaction later in this chapter.

10. In Melia's (1981, p.205) study, students complained that they were often left short of information regarding patients' diagnosis or frequently were not aware of how much the patients' themselves knew about their conditions. She indicates the way in which this interferes with nurse-patient communication. I suggest it has implications for the way in which the nurse carries out her job as limited information is in keeping with task orientated work and a strict division of labour. I suggest that 'nursing in the dark' is a feature of a particular type of work organization i.e. the hierarchical division of labour and routine working in the hospital. In such circumstances, difficulties are engendered for nurses who may wish to communicate with patients as they do not have the necessary information to do so and the way in which work is allocated fails to take account of patients' needs in this respect.

11. As indicated (pp.234-238), students' accounts and my observation of report sessions indicate that ward report sessions are often simply ways of reiterating work to be done and reporting or checking on it's completion (rather than reports of individual patient's progress and/or teaching sessions). As indicated, they are also the time when work is allocated for the shift. At some report sessions I note that no diagnosis is given and students receive general information only like 'not well'.

12. In the two hospitals in which staff nurses gave report, far less reading through of the kardex took place. Staff nurses talked about patients from memory and added whatever information comes to mind and also emphasised 'important' work (non-routine) and allocated work. For example on Hunter Ward at 5 p.m. when the trained staff on the morning shift are going off-duty I noted the staff nurses gathering

around the bed board (a large board on wall with bed nos. - one for each bed and a slot at each bed number to insert the occupying patient's name). I make a note to ask what exactly is happening. Later I am told, it is the staff nurses' report, (the 'hand-over' as morning shift trained staff go off-duty) and that this is an informal verbal report, a separate report for trained staff only and justified on the basis of their separate work shifts.

13. Many accounts suggest that students learned what was happening from patients. The following is an account from my field notes: It was 12 m.d. and meals were being served by Sister Black from a trolley in the centre of the ward. Students lined up with trays to take meals to patients, a student Anne Kershaw says to Sr. Black "Mr. Walsh says he was told he could have something to eat."

14. This has a very direct effect on a nursing role in health education, as indeed has task orientation and a system of working, whereby the untrained provide most of the basic care and have most patient contact.

15. See appendix V11A for an abstract from one such book in St. George's. A work list compiled from accounts in St. Paul's is included in appendix V11B.

16. As indicated (p.234), report sessions are very limited in terms of information given to students. On the whole, the ward routine (p. 241) is relied upon to get the work done and provide care.

17. The existence of a 'work ethic' in the wards has already been identified in existing literature on general nurse training in the United Kingdom (Fretwell, 1982 : Melia, 1981). In the category 'learning the rules' Melia (1981) suggests that student nurses were very soon made aware of what was expected of them in terms of speed, and accomplishing a sufficient share of the nursing work by 'pulling their weight'. She found the 'unwritten rules' that students should 'pull their weight', 'work quickly' and 'look busy' and she suggests "the rules are enforced by the sanctions available, in varying forms, to the work force on the ward" (Ibid. p.198).

18. The emphasis on routine is well documented in United Kingdom nursing literature and this section very briefly indicates its importance to students in the study hospitals. Melia (1981, p. 180) in her discussion of 'getting the work done' explored routines and the means of supervision used by wards and elaborated on the category to explain students' views of their nursing work. She suggests that nursing is seen as work to be 'got through' by an unqualified work force; whilst the qualified look on from managerial positions.

19. 'Temporal' routine tells the nurse when to do tasks and 'motor' routine tells how to do them. The treatment and care for different diseases are incorporated into the routine (Fretwell, 1982, p. 21).

20. Fretwell (1982) indicates that a traditional model of nursing can produce an environment that is not conducive to learning.

21. Melia (1981) reported that 'keeping busy' is a feature of the everyday life of students.

22. One one occasion I observed student nurses enjoined by Sr. Black to talk to a patient. The patient was in hospital as a result of an unsuccessful suicide attempt, was almost completely immobilized and very withdrawn. The concern was that this patient would make another attempt to take her life and sister warned students not to leave sharp objects at the patient's bedside. On observation, student nurses (and indeed all staff) communicated little with the patient, the only communication taking place was related to and in the course of their work performance.

23. 'Peer-group learning' is discussed later (p.252).

24. Fretwell (1982, p.23) states "Demonstration is essential in teaching skills, followed by practice under supervision to correct errors." She says that in the case of learning, rules cannot replace supervision.

25. 'Working Alone' is discussed p.242.

26. Consider the hierarchical arrangements described earlier in this chapter and throughout the thesis.

27. Consider the accounts of report sessions presented earlier (p.234). Report sessions represent a coming together of students and trained staff, yet this encounter is not used as a learning experience (appendix V11C illustrates the constraints on questioning at report sessions).

28. Clinical teachers as well as tutors have their own problems in trying to teach in a service organization. Nuala Ryan notes how she finds it hard, not to get caught up in the ward workload. She cannot teach as she would wish because the student is first and foremost a member of the ward workforce. She notes that she is "not fully in control" on the ward.

29. Consider the ratios of clinical teachers to students on wards (See ch. 6, footnote 1, p.222).

30. This could be the result of improved staff student ratios i.e. more trained staff - but is does suggest that trained staff reserve particular aspects of ward work for themselves.

31. The general tone of trained ward staff's responses indicate that they recognise deficiencies in terms of ward learning, they relate these deficiencies to staffing problems; the system of training remains unquestioned.

32. This request to switch off the tape recorder occurred in other interviews, as students are fearful of repercussions if they are identifiable.

33. As suggested in chapter 6, this coercive power of the organization is something of a myth, as very few students are forced to terminate training.

34. Melia (1981) reports students' desire to 'fit-in'.

35. Chapter 6 indicated how the classroom may present a particular emphasis to students.

36. See nursing theory, chapter 1 (pp.10-12).

37. As indicated (p.231) the team concept can mean little.

38. In some ways, both ward and school may be seen to transmit similar messages regarding authority and control; also the ward's emphasis on physical aspects of care is supported by a collection code in the classroom which fails to emphasize some subjects e.g. psychology (ch. 6, p.199).

39. In this way nurses aspiration to professional status, is almost without any consideration of what this means in relation to their practice -it remains abstracted at the level of theory!

40. A full exploration of this relationship is beyond the scope of this study.

41. Menzies (1971) suggests that nurses use routine and task orientation as a defence against anxiety.

42. A system of training which Davies (1980, p.117) suggests that nurses have been powerless to change as they became entrenched and as the early compromise with regard to hospital based service training 'captured minds'.

CHAPTER 8

CONCLUSIONS

'PIPELINE STATUS'

This study is about students' experiences in the context of the hospital training school, and their interpretation of those experiences. It attempts to present accounts of the student nurse's 'objective' reality as well as her 'subjective' reality as proposed in the guiding principles and the research questions (chs. 2 and 3). Olesen and Whittaker (1968, p.300) conclude their study noting that studies of professional socialization must view the student as an active participant in the process. Dingwall (1975A, pp.12-13) defines socialization as a:

> "Process by which newcomers to a group worked to make sense of their surroundings and came to acquire the kinds of knowledge which would enable them to produce conduct which allowed established members of that group to recognise them as competent."

Given this acculturation model of socialization, the main focus in this study was the experience of the student nurse in the course of her training. However in chapter 2, a relationship between socialization and social structure was also suggested. Berger and Luckmann (1967, p. 172) point out that: "...conversation...takes place against the background of a world that is silently taken for granted." These points reiterate the importance of the informal social system in socialization.

In this study the relationship between socialization and social structure is emphasized as formal and informal social systems interact with one another. The concept of the hidden curriculum suggested the importance of not only the formal but the informal curriculum if one is to understand experiences within the institution, while the acculturation perspective

emphasized that the first step in professional socialization studies must be to understand the experience from the subject's point of view. Hence the relationship between socialization and social structure was an important consideration in the study. In the case of nurse training it indicates that the experience can only be understood in the context of existing structural arrangements of the hospital and society.

Snyder's (1971) work on the hidden curriculum indicated the need to consider items other than those on the official agenda, whilst Dingwall (1982) noted the importance of significant others to the socialization experience (see ch. 2). Millham et al. (1975A, p. 212) also noted the presence and the effects of a hidden curriculum in residential institutions. They suggested that "in the residential institution inmate and staff perspectives form what we call the informal social system..." In another way, Atkinson's (1983) proposal on the relevance of the sociology of knowledge to the study of socialization also pointed to the presence of a hidden curriculum, and in this study the work of Bernstein (1971A) on classification and framing assists in the analysis of 'life in the school for the student nurse'.

This study set out to understand nurse training from the student nurses' point of view with a consideration of the context of that experience. To summarize briefly: chapter 4 deals with the initial transition period and entry to the nursing world; chapter 5 deals with residential life in the nurses' home and suggests a 'total person evaluation'; chapter 6 examines the life of the school and the exercise of control therein; chapter 7 considers the life of the ward, and looks at the assimilation of the short term aims of the institution (e.g. getting through the work) and the role of the student nurse in this bureaucratic context.

The most significant finding of the study was that status represented the single most problematic area in student nurses' accounts of their

experiences (see ch. 3). The report presented these accounts in a 'natural' order, allowing in so far as it was possible, the data to tell the story. As is evident in these chapters, status was uncertain throughout, and the concept of 'pipeline status' is recognition of that. Status is problematic because students experience depersonalization, uncertainty and depowerment within the hospital training school structures. These cluster of experiences are most usefully conceptualized in terms of 'pipeline status' and this is the most significant dynamic of the study.

The preceding accounts (chs. 4-7) suggest a form of control which I use the term 'pipeline status' to conceptualize. Consider the following from whence I derive the term; Lifton (1954) a psychiatrist mentions that 'pipeline' syndrome (feelings of emotional isolation) characterise the military transfer. In relation to repatriated prisoners-of-war he states:

> "The act of being captured, the strangeness of the prisoner-of-war situation and movement from camp to camp in frequently shifting groups, kept the men in perpetual 'pipeline' status until a more physically stable situation developed..." (Ibid. p. 738).

He describes the harsh condition and the uncertainty which characterised the lives of the prisoners'-of-war he studied and notes that:

> "The men reacted initially with great anxiety and some belligerance, subsequently with depression and apathy...There were examples among them of both extremely altruistic behaviour, as well as the most primitive forms of struggle for survival...Some form of emotional withdrawal was necessary to minimise the devastating qualities of the environment. As one repatriate said, 'At first when a buddy died, I'd get very upset and not talk to anyone for days. But after it happened so many times, I didn't seem to care - and I wouldn't feel anything'." (Ibid. p. 733).

Lifton notes then in such situations the brain-washing approach used in emotional assault included three phases in constant simultaneous operation: "isolation, thought control and political conditioning" (Ibid. p. 733). He describes how the prisoners were subject to a 'complex of pressures'. I do not suggest that these methods of brain washing were found to operate in the nursing training schools examined in this study, but rather that the

methods of control identified in chapters 4 to 7, are used in these cases of nurse training to create the 'pipeline' state for student nurses. These experiences could also be described in a very general way as a 'complex of pressures'. The main feature of 'pipeline status' is of a control exercised throughout the socialization process. The form such control takes is explicated in chapters 4 to 7 of this thesis. It is summarized briefly below.

In this study, 'subjective reality' for student nurses was considered in the context of objective reality. As indicated in data chapters, that reality was rigid and inflexible and the hospital training school was seen to resemble aspects of life in a total institution. However, I do not wish to suggest that the hospital training school is a total institution but that it has a 'pipeline' effect, rather than a totalizing effect i.e. it does not take over the whole of students' lives; they still manage to go to discos, have boyfriends, get engaged and even married. It is in relation to their role in the hospital training school that limitations and constraints are set. The concept of the 'total institution' is important as some of it's features contribute to the mortification of the self. This, combined with the emphasis on 'being up to standard', total evaluation, the inflexible educational structure and a pre-determined work role in a bureaucratic organization, assists in the imposition of controls and limitations in the work setting. 'Pipeline status' is the form in which the student nurse can be realised as a safe worker (1).

'Pipeline status' is used to indicate the way in which constraints and limitations are imposed on the student nurse. In the course of their training, student nurses experienced their own low status, felt under surveillance and had to operate as part of a hierarchically structured workforce where they were often deprived of information. Their work environment could be threatening as they 'learned on the job' and the

educational structure offered little support given its inflexibility and rigidity. Structural features of 'pipeline' institutions include some bureaucratic and total institution features e.g. a hierarchical authority structure, division of labour, possibilities for information control, admission procedures, opportunity for 'pace-setting encounters', and a pre-determined role for incumbents. For the individual, these features are likely to give rise to powerlessness, uncertainty and depersonalization. The institution's gain is conformity and compliance to institutional role demands (2). This type of organization cannot be truly coercive, incumbents are voluntary and hence the method of control is through the creation of 'pipeline status' ('pipeline status' is outlined in Figures 3 and 4).

To summarize, 'pipeline status' relates to a form of control and is used to conceptualize a situation in which individual experience is characterized by depowerment, mortification, depersonalization and uncertainty. The student nurse's experience of the hospital training school is one of being 'in the pipeline'. In the immediate setting, I suggest that this results in compliance and conformity as individuals depend on existing structures and routines in order to 'get by'. As indicated in this study (see chs. 5 and 7), 'pipeline' structures may contain features of bureaucratic organizations and total institutions as individuals experience control within an institution which does not have any real coercive power over them, and where their co-operation is required to achieve organizational goals (chs. 5 and 7). It is these two latter features which distinguish 'pipeline' contexts from 'total institution' contexts where they are absent. As per Figure 3, column 2, students' accounts suggest three main experiences which characterize their training, viz depersonalization, uncertainty and powerlessness.

Figure 3

PIPELINE STATUS

The Context	Individual's Experience	Outcome
A hierarchical structure		
Admission procedures and 'pace-setting' encounters	Lack of autonomy	Conformity
A pre-determined role for incumbents	Dominance and Subordination	Compliance
A new or strange environment in terms of work, school and residence	Routinization	(to organizational role demands)
Organizational enticement to membership		

Figure 4

THE STUDENT NURSE'S PIPELINE STATUS

The Context	Student's Experience	Outcome
Hospital Training School		
Total evaluation (chs. 5, 6 and 7)		
An inflexible education structure (ch. 6)	Powerlessness	Conformity and compliance with the organizational role i.e. working within existing rules and ward routines
A hierarchical division of labour (chs. 4 and 7)	Uncertainty	
A pre-determined work role with close patient contact and 'worker' responsibilities(ch.7)	Depersonalization	
R.G.N. qualification a possibility		

The foregoing constitutes students experience of 'pipeline status'. It conceptualizes the experience of the student nurse and relates it to what is essentially a structure of control. Data presented in this report indicate (Figure 3, column 1 - the context) that the different message systems of the hospital training school, despite their diversity, are in many ways complementary. All transmit messages of subordination, domination and powerlessness as students experience control. They experience this in a strange and sometimes frightening environment where an organizational enticement to membership exists for them (3). This latter feature also distinguishes the experience from that within the total institution. From accounts, it seems as though, after initial early interaction, that control is mediated by structural factors with only occasional 'pace setting' encounters as incidents occur, or, on other occasions such as moving up in rank and the commencement of 'block'.

'Pipeline status' as outlined (Figures 3 and 4) attempts to conceptualize the student nurses' problematic status and to accurately reflect her experiences in the hospital training school. I recognise that the experience and its possible effects lends itself to further examination and theoretical discussion but such an undertaking is not within the scope of this present work. I now discuss some methodological and theoretical aspects of the study.

THEORETICAL AND METHODOLOGICAL CONSIDERATIONS

'Pipeline status' serves to emphasize the importance of context in any socialization study and the need to understand factors underlying the nature and extent of the 'dialogue' permitted whilst in the institution. The weightiness of control by the institution in this study limited

students' choices as it kept them in 'pipeline status' and they tried to 'fit-in', wanting very much to make-the-grade and stay-the-course. As will have been seen in this and the preceding chapters, the concept of 'pipeline status' was developed out of an understanding of both interactional and social structural experiences, of both formal and informal social systems. I suggest that this indicates the inadequacy of socialization studies which fail to consider both. The authority structure is as important as the hint, the look, the glance in understanding the socialization experience. Within the different message systems outlined in Figure 3 and discussed in chapters 4 to 7, complementary messages are transmitted. It is a reflection of the current state of the field of professional socialization studies that the theoretical frameworks used are diverse, reflecting work from the field of medical sociology and the sociology of knowledge (4).

The concept of 'pipeline status' indicates gaps in previous approaches to socialization within both the sociology of education and medical sociology. It shows the need to develop both frameworks if the training experience of the student nurse is to be understood. Theoretical constructs from both areas contribute to understanding the context and student nurses' experience of 'pipeline status'. The inflexible structure of educational collection codes in the school of nursing is matched by an equally rigid structure in the clinical areas, and in the early days of training, students' experience an unbending emphasis on the correct behaviour and appearance i.e. of 'accomplishing profession'. A theme of control runs throughout students' experiences, suggested by concepts from diverse theoretical frameworks. Acculturation studies on professional socialization (most particularly Dingwall, 1974A); Atkinson's (1983), comment on the insulation of functionalist and interactionist approaches, his injunction regarding the sociology of knowledge and professional socialization; and the concept of the hidden curriculum, suggest that in

discussing socialization, the wider social system in which socialization takes place must be considered. In terms of my typology (Figure I, appendix 11), my model of 'pipeline status' is clearly located in a perspective, which considers both subjective and objective reality important foci in studies of professional socialization. As this study illustrates, the sociology of education or medical sociology do not in themselves present a unified theory for analysis of this area, but rather have from different perspectives considered different aspects of it. This study attempts a consideration of both objective and subjective reality by drawing on a range of theories in the sociology of education and medical sociology. I suggest that the value of the resultant model of 'pipeline status' lies in its attempt to consider both objective and subjective reality, and thus to reflect students' experiences.

This study clearly indicates that structural factors are important in understanding interactional factors. Interaction always takes place in the context of a particular structure and this is important. It is of limited value to examine and discuss interaction out of context. Atkinson (1983) says that the contrasting work of functionalists and interactionists has resulted in the neglect of some areas of professional socialization with the result that the field failed to develop to any significant degree. Functionalists tended to emphasize homogeneity and consensus of professional groups focusing on unproblematic assimilation by students, whilst interactionists focused on 'situational learning' and developed concepts like 'student culture'. While such accounts were interesting and informative in their own way, their insulation from each other leaves gaps in the study of professional socialization. Atkinson (1983, p. 240) states that interactonists fail to examine the 'process of training' and this must be addressed; more particularly he states that further examination of the 'social organization of curriculum and knowledge transmission' in general and in relation to specific groups is necessary. But it has been pointed

out (Dingwall 1982, p.2) that if this is to happen it is necessary to expand on earlier work, not simply by including a perspective on knowledge, but, "by improving our basic conceptions of the training organizations themselves" thereby addressing the problem noted by Atkinson (1982) of the 'insulation of the socialization experience'.

Silverman (1985, p.79) states that interactionist and structuralist sociologists while claiming to incorporate each other remain 'split into warring camps' and he indicates some responses to this macro-micro polarity. He describes the problem of integrating structuralist and interactionist analysis as a problem of "integrating macro and micro level of analysis" (Ibid. p.91), he notes that some writers have succeeded in this task (Douglas, 1975; Dingwall et al. 1983) where others have failed. Silverman (1985, p.96) suggests "that sociologists have much to learn from anthropologists' long experience of attempts to describe whole cultures" and hence his solution to the macro-micro divide resides in a consideration of ethnography which he says as a concept "involves a recognition of the interdependence of theoretical and methological issues" (Ibid. p.96). As per Atkinson and Hammersley (1983), he concludes that ethnography as a practice should not be confined to interactionist concerns but should include "aspects of ethnomethodology, structuralism and even neo-positivism" (Ibid. p. 97). Following Dingwall (1981) he suggests ethnomethodological ethnography (EE: Silverman, 1985, p. 108). In the present study, the problems of integrating work on the sociology of knowledge and work on medical sociology, of considering both objective and subjective reality, represents the problem Silverman discusses of marrying structuralism and interactionism, of combining macro and micro sociology. This present study has shown the value of incorporating structuralist and interactionist sociology.

As indicated in chapters 2 and 3, an 'open' theoretical approach was

maintained (theory was not imposed in the data collection or assembly stages), as was a qualitative methodology. In line with the aims of the study, throughout this report I have attempted to concentrate on letting the data 'tell the story', while maintaining a theoretical sensitivity. As in Melia's (1981) study, the aim was to describe training from the student nurses' point of view, and it used an approach whereby data were allowed to generate concepts. This present study differs from Melia's (1981) not in aim, but in method as it used a variety of methods for data collection and attempted to consider all aspects of the student experience. The study triangulated data in terms of different sources and different methods (Atkinson and Hammersley, 1983, p. 181). It is suggested that triangulation, both theoretical and methodological is important. As indicated (ch. 2), the ethnographic approach as it presents the actors' world challenges the 'dangerously misleading preconceptions' that researchers may bring with them. In this study the interlocking techniques of interviewing, diary keeping, participant observation, knowledge of the work situation and reflection on likely-to-be relevant theoretical frameworks were used.

The study utilized not only data triangulation but methodological and theoretical triangulation (Denzin 1978), as data were approached with 'multiple perspectives' in mind (Atkinson and Hammersley 1983, p. 181). Eldridge (1973, p. 281) notes: "Theoretical triangulation involves the researcher in the analysis of the same set of data from different theoretical perspectives". In this study, data relating to various areas of students' experience were analysed in the light of different theoretical contributions and this triangulation of theory enhanced the understanding of the experience. In the case of theory triangulation, Atkinson and Hammersley cite the following from Bensman and Vidich (1960, pp. 165-6) who state:

"When one set of theories does not exhaust the potentialities of

> the data, other sets can be employed to point to and explain the facts which remain unexplained."

I suggest in this study that the triangulation of theory, represents not so much new theories, but as Bernstein (1971B) indicates, new ways of looking so as to improve understanding. He suggests that it is better not to use the word theory and perhaps it is more fruitful to ask:

> "Do these encourage a shift in perspective so that we can see received frames differently and even a little beyond them?" (Ibid. p.20)

Theoretical 'strands' incorporated in this study all contribute to understanding - they relate directly to the data but arise from different sociological fields; the sociology of education contributes to an understanding of school experiences whilst the sociology of medicine and the sociology of occupations contributes to an understanding of ward life and 'accomplishing profession'. This diversity is a reflection of the developing awareness of the need to expand the area of study in professional socialization. Theoretical frameworks are only useful in so far as they contribute to explanatory power - once they define the limits of a study by virtue of their scope, they are a hindrance rather than a help in the pursuit of new knowledge (5). Theoretical triangulation in combining existing theory helps to promote conceptual growth rather than limit it. This study in its triangulation of method and theory has been an experiment with such triangulation.

As indicated (ch. 2), Olesen and Whittaker (1970, p.196) point out that concepts should guide, sensitizing to new ideas thereby leading to the construction of new ideas (6). It is with this statement in mind that I offer the concept of 'pipeline status' as an elaboration and development of 'fitting-in' (Melia 1981). This study places the concept of 'fitting-in' in a different light and indicates possible effects on the individual nurse and her practice. This study did not set out to replicate Melia's (1981) study but was rather more in the tradition of broader studies of

occupational socialization (Dingwall, 1974A; Becker et al. 1961; Olesen and Whittaker, 1968). My own study adds to this body of knowledge in its inclusion of interviews with tutors and ward staff who constitute significant others for student nurses, and its exploration of the presentation of knowledge in the classroom. The intermeshing of structural and interactional factors as they combined to produce the 'pipeline effect' derived very much from the flexibility of method and multiplicity of existing theories which informed this study. Accounts of subjective experience alone would not have produced this work, rather it would have dealt with but one aspect of it, as would a study with structural factors as the sole unit of analysis.

To conclude, this exploratory study demonstrated the interrelationship of theory and method illustrating the value of open and flexible methodological and theoretical frameworks in exploratory work. It contributes to work on professional socialization and nursing education in a number of ways. In terms of professional socialization, it contributes to an awareness that the interactionist perspective should be extended to take account of structuralist aspects of the experience, as Atkinson (1983) suggested. In the case of nurse training, it conceptualizes student nurses' 'subjective' experience in terms of 'objective' reality i.e. the context of those experiences (7). It clearly indicates the importance of considering the context of the socialization experience and as Dingwall (1974A) also suggests, it indicates the need to relate this to claims professionals make about the work they do. It indicated that the presentation of classroom knowledge was an important aspect of the student experience and as per Dingwall (1974A) it supported the importance of including significant others in any study of professional socialization (8). This is not to suggest that the student is no longer central to studies of professional socialization; it is desirable that the student experience continues to be the focus, but with the development of an

analytical framework wider than interactionism and more coherent and unified than presented in this study. I suggest that this study contributes to an understanding of the training experience and the role of the nurse in relation to health education as it indicates an incompatibility between the reality of existing practices and the ideals of health education and nursing theory. I now discuss the findings of this study in relation to health education.

EPILOGUE

Nurses as Reluctant Health Educators: A Problem of the Experiences and the Context of Professional Training?

I started this report (ch. 1) by highlighting a particular problem and I should like to conclude by addressing the same problem, that is, the failure of nurses to fulfil a health education role or in broader terms, the failure of nursing theory in relation to this role to make an impact on care. A health education role for nurses appears to be congruent with professional nursing aspirations. Yet the ideal (ch. 1, pp. 10-14) is premised on a view of hospitals and training which existing literature and this study indicates is imaginary rather than real. Briefly, this study indicates that the work students do and their educational provision is indifferent to health education, because health education is incidental to the running of the hospital (9). With a view to making them effective, safe service workers, student nurses are subject to a system of control.

Although health education as a subject featured in the nursing syllabus, what was taught and the way in which it was incorporated into nursing education was completely arbitrary, and , when discussed in

interviews with students, often subsumed under the general topic of hygiene (10). Despite its appearance in the nursing syllabus, when asked about health education, students fumbled and asked "do you mean hygiene?", yet on probing, some did describe other aspects of health education (11). Although health education featured in the nursing syllabus it received little independent timetabling in class and little emphasis as part of other subjects. The understanding of health education as empowerment, as something facilitating patient independence was clearly not transmitted (12). The medical model dominated the timetable, given the strong classification and framing in the classroom and the pervasiveness of the hospital's hierarchical arrangements. Health promotion for the student nurse was prescriptive and the concept of self-reliance or autonomy was not a feature of it: Students were not allowed to be responsible for their own actions even in off-duty time. Neither was independence encouraged, although promotion of independence and individual responsibility are prerequisites for effective health education. If such attributes are not fostered amongst student nurses, they in turn, are unlikely to foster them amongst the patients they nurse. I suggest that nurses' 'non-involvement' in their own education and lack of facilitation of self-development (see ch. 6; Bernstein, 1971A; Barnes, 1975; Pring, 1976) fails to prepare student nurses for the partnership-in-care necessary if the aims of nursing theory and health education, in terms of promoting patient independence, are to be met. Barnes (1975, p.149) notes:

> "If we wish to encourage pupils to be able to adapt to new problems, and to take responsibility for their own actions rather than to follow custom, then a passive view of learning will not do."

In terms of data presented in chapter 6, it was seen that the structuring and ordering of knowledge in the classroom perpetuated gaps between theory and practice. It failed to incorporate the students' subjective reality, consequently it was unlikely to help students to respond to the individual

needs of patients. This occurred as students themselves were depowered. In contrast to Fox's (1975) work on medical students, student nurses were prepared for a certainty which cannot exist in nursing practice, if care is to be individualized.

The 'life of the wards' (ch. 7) also indicated that structures for care provision were not person-centred. Care was routinized in a hierarchical setting and students learned routine working as a way of coping with ward work and patient care. Of direct relevance to a role in patient teaching and also reported in Melia's (1981) study is that student nurses learned that 'talking isn't working' and in the hierarchical setting of ward work were often excluded from information about patients in their care. If patient teaching took place, it was one of the invisible areas of staff nurses work; even if it took place on some occasions, students never witnessed it and therefore had no role models in this area of practice. This led many to the conclusion that patient education was not an important part of their work.

The imposition of homogeneity and exposure to total evaluation acted to depersonalize the student nurse and assisted her compliance with institutional definitions of role and self (see chs. 4 and 5). In the hospital training school generally, students learned that conformity, not initiative, was rewarded and this resulted in a 'fitting-in' to a structure of care provision that was not patient centred. Apart from preparation for work in areas of primary care, which was almost totally neglected as all messages confirmed the predominance of acute hospital care, messages transmitted from structures and interaction in the hospital training school operated against the focus of care being the patient (13).

This study suggests that the experiences of training, both structural and interactional, emphasize to the student nurse a role demanding passivity, conformity and routinization, plus a system of care involving passive dependent patients. At present, training prepares students for a

role in the medically dominated acute care setting. It offers some background for the work they are required to do as students. Melia (1981) also suggests this. It incorporates the transmission of knowledge for examinations, which are once again geared to assessing knowledge, as transmitted by tutors and as regurgitated by students, without any reassembling or reflection. Success on such terms tells us little about ability or capability as qualified nurses, except in the existing rigid, task-orientated structure and the 'successful' student's ability to conform and 'fit-in'. Neither syllabus or examination structure demand a dialectic or exchange between teacher and taught, but rather appears to promote straight transmission; consequently no exchange takes place and the student nurse can remain untouched by her training or educational experiences - she continues (as Bernstein suggests pupils in similar processes do), to use her own commonsense knowledge to provide her modus operandi. Where influence is exerted, it is in terms of the dominant medical model. If the school of nursing fails in this educational sense, then the only function it fulfils is as an instrument of the hospital training school in the control of students. This raises the question of 'training for what?' to which I return later in this chapter.

At one level, these structures and the system of control they activate, could be seen to stem from and to be justified in the context of reliance on student labour. If this is the case then the problem can be seen as one of locating the degree of control necessary for the safe delivery of care by student nurses. It is questionable if an equation can be found between these two in terms of educating student nurses (14, 15). In nursing, consideration must be given to the trade-off between (a) safe care, (b) the quality of care, (c) the significance of the development of the nurse as a person, and (d) the nurse as a flexible and responsible health worker. I must also point out that (a) and (b) above are not

necessarily mutually inclusive. Care may be reasonably safe to the detriment of responding to the individual needs of patients and many studies attest to failure with regard to the latter (Ley and Spellman, 1967; Cartwright, 1964; McIntosh, 1977, etc)., whereas (b) and (c) are more likely to be mutually inclusive given the evidence on meeting patients' needs - 'the cared for are more likely to care for others' (Bush and Kjervik, 1979; Dyer et al. 1975; Revans, 1964; Hopson and Scally, 1981, p.75). Social control is to some degree necessary in all communities, but this research suggests that the extent of current control in nursing training in Ireland is dysfunctional to the development of the nurse as health educator and to the implementation of nursing theory. A balance needs to be found between the degree of control necessary to bring off safe patient care and to release the student nurse from her 'pipeline status' i.e. preparing her for a 'partnership-in-care' and a wider role in health care generally.

To date, no such balance has been suggested in nursing in Ireland. As indicated, the Working Party Report (1980) which is the most recent report on general nurse training in Ireland, suggests a common basic training with students as service employees (16), and recommendations at the present time for preparation for primary care simply represent the minimum E.E.C. requirements of one week's experience in home nursing (Ibid. p.109). The Working Party Report (1980, 2.2.1., p.25) recognises trends in the health services in terms of the development of primary care, yet does not recommend much real change in this respect. In contrast, two recent reports in the United Kingdom both identify the service role of student nurses as constituting a major barrier to the development of nursing practice (17). They suggest movement away from this situation, recommending that students pursue a training outside of their given service function, but envisage the National Health Service as the main source of finance. The models espoused (like the models of nursing care), are very

far from the reality of practice and it remains to be seen if these models for education are more tenable in reality than the models for practice. Such innovation is to be welcomed in the setting but innovation and controlled experimentation with respect to change in some of the problem areas highlighted in this study may well indicate the imperviousness of the structure to change (18, 19).

Summary

To summarize, the socialization of the student nurse is as a result of interaction with both formal and informal curriculum. The structural organization of the hospital training schools studied is important in transmitting existing interpretations of the nursing role. This has implications for change in nursing practice, in that it suggests that nursing structures must change if health education is to be a part of the nursing role. Armstrong (1977, p. 247) suggests that structures of undergraduate medical education may ensure an identification with hospital work, but not with primary health care. He concludes "reforms of curriculum content without a critical look at educational structures are unlikely to change this state of affairs." I concur with this, but suggest that hospital structures (within which student nurses train and work), may also militate against an individualized approach to care (an approach which by definition incorporates a health education role), even within the hospital's acute care area. I suggest that this is as a result of the bureaucratic way in which nursing care is delivered and the way in which those working in the settings see, or are forced to make, choices about their priorities. The organization for the delivery of care must be 'person-centred' if care is to be 'person-centred', that is, if nurses are to function as health educators.

As I see it, three problems exist in nurse training; the first relates to the way in which the nurse learns to see and perform her role in the

acute care setting, the second refers to her orientations to and preparation for work in areas outside the hospital services. Both these latter problems are interrelated in terms of the way in which nurses see and relate to patients and this must be the basic issue to be addressed in preparation for nursing practice. The third problem is the most easily dealt with, viz the knowledge and skills necessary to do the job - any attempts at the latter without tackling the former will be of limited success.

'Student Nurses can't change the World'

The Working Party Report (1980) recommends a different approach to the problems of nursing practice than that offered by the Commission on Nursing Education (1985) and the Project 2000 Report (1986), the former sees no real need for changes in the location of nurse training. However, all imply that if one changes nurse training, then one can transform nursing practice. While such change is certainly a prerequisite to change in nursing practice, depending on the degree of change required, it may be dangerously misleading to assume that this is all that is required. Buckenhem and McGrath (1983 pp. 104-5) discussing change in the Australian health services (20) comment:

> "Given the nature of the student's experiences in the social world of the hospital, perhaps the registered nurse's behaviour does not seem so strange after all. For if the nurse, as a student, is subjected to a system which demands deferential and subordinate behaviour, which teaches her to consider herself subservient, and which insists she view the patient as external, if not inferior, to the health team, is it any wonder that, after registration, that nurse displays those same characteristics? After three years of practising those behaviours and internalizing those attitudes, surely it is unreasonable to expect her to perform in any other way? It seems perfectly understandable, then, that the registered nurse should exhibit behaviour which is so obviously at odds with that implied by the rhetoric of the profession. For the registered nurse, the real world is dominated by the social dynamics of the health team, just as it was throughout her three years of training. The emphasis may have shifted slightly from the nurse/nurse relationship to the nurse-doctor relationship, but it is still the relationships within the team that provide her with her nursing self-concept."

I suggest that it is more than the dynamics of the health team that subordinates the nurse and that the very structure and organization of hospital care and training are a root cause. Writing on the patient care unit, Reeder and Mauksch (1979, pp.218-9) observe:

> "Osborne (1975) has commented on how its authoritarian organizational structure of the medical model impoverishes the potential of making of the participating professionals. The near universality of this model as well as the fact that it is not based on the achievements, contributions and potentials of the individual participants give rise to this impoverishment. Even in work settings and organizations considered to be interdisciplinary, the contributions of the various disciplines are often orchestrated according to the traditional hierarchy of the medical model."

The influence of the medical model on nursing appears to militate against the potential health education aspects of the nurses' work and the all encompassing caring role envisaged by some nursing leaders - an educational model would be more suitable to the development of both. If care is to be health and person orientated, then the educational programme must also be health and person orientated. Likewise, so must the institutions, or the programmes, within which clinical experience is obtained and nursing care delivered.

In Ireland, as in the United Kingdom, medicine and medical concerns dominate not just the hospital service but the health services, and nursing role change will encounter obstacles in this respect (Buckenhem and McGrath, 1983; Rosenthal, et al., 1980). The Department of Health which controls training and hospitals in terms of providing funding, must be prepared to extend its support beyond the hospital service. Esland (1971, p.73) notes:

> "Bernstein has suggested that the changing ideational structures of the curriculum - in moving from closed to open relationships - are related to changes in the social infrastructure which articulates them, and to wider aspects of social change".

Given the outline plans for funding of proposed changes (Project 2000 Report, 1986; Commission Report on Nursing Education, 1985), it is questionable if hospital authorities (The National Health Service) will

fund, not simply the replacement staff for student nurses, but an educational programme without imposing limits and constraints on education. Given its aims, it is inappropriate that nursing practice and education be developed mainly in relation to acute hospital service needs. To this end, it is appropriate that educational authorities make some provision for nurse education, and that nurses make the case for location in an established educational context, so that educational nursing structures are not under the auspices of hospital services. This study suggests that to change the experience of basic hospital training, change must take place in a number of other spheres. These include the views and attitudes of all nurses (from the most senior to the most junior), towards their nursing role, their nursing colleagues and towards patients, a change in nursing role orientations, a shift away from the reliance on student labour in training hospitals, changes in the curriculum and even the basis of the curriculum itself, and a clear mandate for education in nursing by placing education in the hands of educationalists and away from the hands of those geared to service needs - a dual responsibility places impossible and unfair demands on incumbents.

This study suggests that piecemeal changes in schools of nursing are of limited effect and that the structuring, content and presentation of the curriculum are but representations of the wider power structures within which training and indeed nursing takes place. It is important that nursing leaders are aware of the enormity of change that is required to realize their stated ends. This study indicates that change can only come about through a slackening of structural and interactional controls and a positive attempt in the educational and work setting to actively involve nurses in their own work and learning (21). As health education demands a redistribution of power to recipients, so if nurses are to function as health educators, their preparation must involve them in a redistribution

of power. Health education, and its revolutionary philosophy given the prevailing attitudes of health professionals (ch. 1), must underwrite the whole of the nurse training programme. If nurses are to encourage patients to ask questions and take control over their own health , they must be prepared not only formally with skills, information, appropriate aims etc., but in kind, by their active involvement in their own education i.e. with more emphasis on an empowering educational model than a medical model, with movement from a collection code to an integrated code. Bernstein (1971A) discusses in some detail how integration might take place. For any form of integration to be achieved, he indicates that there must be a 'relational idea', a 'supra-content' concept, which concentrates upon general principles. This integration is distinct from what he calls a 'focused curriculum', i.e. different subjects focusing upon a common problem. He suggests that 'relational concepts' act 'selectively' upon the knowledge within each subject to be conveyed - the details of subjects are likely to have decreased importance thus focusing upon the deep structure rather than its superficial structure. This leads to a stress on general principles and "the concepts through which these principles are obtained." (Ibid. p.60). In nursing, the focus might be the concept of health and its relationships to other subjects with resultant integration of various subjects and consequent emphasis on general principles. Bernstein (1971A, pp.60-61) suggests a further spin-off from this when he suggests that this is likely to result in situations where teachers will be more concerned to emphasize how knowledge is created than the acquisition of states of knowledge. However, a problem may present in relation to integrated codes, Bernstein (1971A) notes "...at the level of socialization the outcomes of integrated codes could be less predictable". As he states, risk is involved in such change. At another level, integrated codes may be more intrusive on the student, given the structure of training in this study. Integrated codes must be considered in the light of controls on

appearance and behaviour and the current pervasiveness and intrusiveness of the hospital training school (22).

A full discussion of ways of achieving integration is beyond the scope of this study if it is to do more than make superficial recommendations. However, Bernstein's (1971A) 'integrated code' provides a suggested model for curriculum structure, and I suggest that his work on this area would bear fruitful examination should restructuring of nurse education be under consideration. Student nurses also need an environment where they can learn in safety and security as against the current 'pipeline status' where trial and error learning and fear of individual responses is the norm (chs. 4-7). Unless counterbalanced, 'pipeline status' as it limits self and professional development, can become self-generating and self-perpetuating as student nurses' experiences in 'pipeline status' become the basis of guidelines for future action. Melia (1981) suggests that it is plausible that newly qualified staff nurses continue to function using patterns of working they have learned as students. I suggest that this is even more plausible given 'pipeline status' and if nurses continue to work within similar organizational settings.

Conclusion

To conclude, if it is considered desirable that nurses fulfil a health education role and provide in nursing terms 'total patient care', then some changes are necessary. As a first step to introducing change an appraisal of the extent of some of the problems identified in this study needs to be undertaken followed, where appropriate, by innovative pilot courses with intent to introduce some structural changes and provide the necessary orientations, health knowledge and skills (23). Given the 'pipeline status' of the student nurse suggested by this study it seems unlikely that any role change (and health education or total patient care is a role

change) can be brought about without some external intervention (24). The need for external intervention for this change is doubly emphasized in times of economic recession when jobs are less certain and the number of applicants for training far outnumber places available (Working Party Report 1980), indicating that relative powerlessness may be increased for nurses at these times. Without adequate supportive interventions, students, in their interaction with the hospital training school, will continue to pick up the institutional messages described and experience depowerment, subordination and a lack of status and control as they remain in 'pipeline status'. Some basic questions must be answered before one can consider the benefits of the present system of training. The first of these to answer is one taken for granted in chapter one but posed earlier in this chapter, that of 'training for what?'. Should the nurse and indeed who wishes the nurse, to fulfil a wider nursing role? (25). Is the nurse to be more than the handmaiden of medicine , as Buckenham and McGrath (1983) put it, is she to be trained to allow the health team's needs to take priority over those of the patient? Even within a system of medically dominated nursing care, the present system of training can be seen to be wasteful of personnel and resources. Are nurses receiving a training which simply allows them to take over medical tasks as medical practice deems fit, but for the most part, trains them for three years to perform low level tasks in a routine way? On the other hand, the nurse could be educated to innovate and make the patient her priority. Educated for this, she will be prepared for work in anticipated future care settings (Working Party, 1980; Commission on Nursing Education, 1985; Project 2000 Report, 1986), e.g. the long term care of the sick at home, or in institutions, or in preventive fields, and not simply in the very limited acute care setting of the hospital as is the present situation. The control of and authority over students in the present structure must be questionable (however understandable it may be). It would appear that

nursing as an occupation, must answer the question, training for what? Are nurses to be trained or educated; are they to be prepared to meet short term goals in the hospital service or long term goals in the health services? (26, 27).

In relation to the students' experience of training conceptualized as 'pipeline status' and keeping in mind the potential for growth and development inherent in health education philosophy, I conclude this report with the words of a student nurse. Rachel Corrigan emphasizes the positive side of nursing, yet for her the negative side is always there, she states:

> "I have never really got to that stage where I wanted to leave. There is always something that picks you up again, someone says something nice to you....I don't know why, if I was getting into trouble all the time I'd have something to give out about. I just dread the unknown and it's terrible going by other people's reports. I keep saying it's going to come yet, but maybe I'll get through."

and St. Anselm's twelfth century views on education:

> "If you planted a tree in your garden, and bound it on all sides, so that it could not spread out its branches, what kind of tree would it prove when in after years you gave it room to spread? Would it not be useless with its boughs all twisted and tangled?"

FOOTNOTES

1. I do not wish to suggest that the hospital training school is a total institution, because students do not live a 'formally prescribed' round of life but suggest that aspects of total institutional life are helpful in understanding the student experience.

2. 'Pipeline status' limits action only in that immediate role in the organization.

3. Existing circumstances in Ireland, whereby students compete for entry and are strongly motivated to qualify as registered general nurses, may enhance the transmission of such messages - see appendix 1 for details of applications and admission rates to training.

4. Atkinson (1983) suggested the need to incorporate work from the sociology of education.

5. In the development of grounded theory, Glaser and Strauss (1967) suggest that as data collection and analysis proceeds the researcher should wait and see if existing theories are linked to emerging

categories rather than imposing them at the start.

6. Olesen and Whittaker (1970,p. 221) state that the question of professionalization cannot be ignored by students of professional socialization. In this study, professionalization is discussed briefly in chapter 1 whilst chapter 4 demonstrates its accomplishment. In practice 'pipeline status' effectively precludes elite professional aspirations becoming reality.

7. A context which I suggest requires fuller exploration than that presented in this exploratory study.

8. This study owes a debt to Dingwall's (1974A) work on health visitors whereby he discusses socialization as social organization.

9. People in 'pipeline status' are in an organization which is managed on the basis that workers need not think for themselves - those who do are likely to find themselves in conflict with the organization. What matters is that students learn to 'get through the work' quickly and safely.

10. In the syllabus of training for registered general nurses health education is listed as a topic area to be covered (An Bord Altranais, 1979, p.14). Other than subdividing the topic into mental health and physical health no other information is given.

11. On the whole students felt they had covered health education as a subject in nurse training: they listed items they felt were important e.g. vaccination of children; relation of disease to environmental factors; dangers of smoking and drinking; drug addiction; prevention of cross infection; hygiene; exercise; diet; community health; first aid; ante-natal and post-natal education; routine screening; education of diabetic patients, stoma patients, and tracheostomy patients; sanitation; housing; ventilation and heating. None described the situation whereby the nurse facilitates patients taking control of their own health.

12. In the United Kingdom, the Health Education Council (1980) found, in a survey of health education teaching in schools of nursing, that there was little agreement on what constituted health education and little was taught. It indicated that many other factors are involved in health promotion, and that it cannot be presumed that nurse training syllabi incorporate the teaching of (a) the appropriate knowledge or (b) skills e.g. communication, teaching, counselling. Experimental programmes on health education in nursing are under way. (Amos, 1985; MacNeil, 1985; Mayhew, 1985). I would suggest that the main factor involved in promoting health education among nurses is preparation (beginning in training at a personal/interactional level) for a partnership-in- care such as that described by Armstrong-Esther et al. (1985).

13. Like Armstrong's (1977) study, classroom structure also promoted a medical or disease focus as it perpetuated existing structures of dominance in the hospital.

14. This is the tension between order and education indicated in ch. 6 p. 220).

15. It is not simply the student who is controlled in this setting.

Tutors and ward sisters are also controlled - the latter are constrained by the day-to-day necessity of running a ward with twenty to forty ill patients and a mainly untrained labour force. The former (who might at first glance seem to have more opportunity for control over their work) are contained also by artificial controls in having to keep pace and account for classroom sessions with consequent little chance for independent action.

16. The Working Party Report (1980 , 4.3.2 <4> p.41) states:

"While it is inadvisable to continue counting on students to form the greater part of a nursing establishment, it is equally inadvisable to contemplate creating a situation where they will have no commitment to clinical areas and where learning nursing skills is only achieved by isolated visits to the wards. Most of the time in training is spent in acquiring adequate nursing skills which are practised in the normal work situation in the hospital."

17. The Project 2000 Report (1986, p.70) recommends that "there should be a new registered practitioner competent to assess the need for care, provide care, monitor and evaluate and to do this in institutional and non-institutional settings (5.14, 5.17-5.20)" and "students should be supernumerary to NHS staffing establishments throughout the whole period of preparation (7.6)." While the Commission on Nursing Education (1985) proposes "two interlocking remedies. The first requires a transformation but not the dissolution, of the intimate relationship of the education of the nurse on the one hand, and the delivery of the nursing service on the other. The second requires a translation into the mainstream of higher education of the institutions and staffing of nurse education." (Ibid. 5.2, p.47).

18. Stenhouse notes the imperviousness of the hidden curriculum to change.

19. In the discussion stage of the Project 2000 Report (1986), potential problems are emerging particularly with regard to funding and the students' service role; these problems are interrelated.

20. That similar problems arise in health care settings as far away as Australia suggests the need for comparative work. By way of response Australian nurse training is moving out of the hospital setting.

21. Outside of these, there are also macro factors, viz questions of wider control and subordination, to be considered. The question of control, in a patriarchical society of a predominantly female occupation, for instance, is a question not addressed here but discussed by Ashley (1976), Garmarnikow (1978), Treacy (1979). Davies (1980) indicates some of the difficulties of change.

22. Bernstein (1971A, p.66) notes how movement to integrated codes can result in increasing students' exposure and vulnerability. This occurs because of the greater exposure of self that is required with such codes. This point emphasizes the need in nursing, to consider all experiences of training when considering changes. The intrusiveness of the hospital training school is already great (chs. 4 and 5), to add to this by movement to an integrated educational code without other changes will increase the students' already high vulnerability to exposure in the hospital training school.

23. It may be desirable to explore the findings of this study using a wider, more representative sampling frame and a more quantitative approach.

24. For example, external intervention from those who control nurse training, viz the Department of Health and An Bord Altranais. Such external intervention might include: changes in the syllabus for general nurse training, a reduction in the service's reliance on a student workforce, movement from total encapsulation within the medical model, changes in the organizational structures of nursing care in hospitals, and changes in the way in which nurse training is funded.

25. Research is already providing the answer to this question as it indicates patients' needs and gaps in care (see ch. 1).

26. The Commission on Nursing Education (1985) and the Project 2000 Report (1986) attempt to answer this question and follow it to its logical conclusions. The Working Party Report (1980) is less clear, noting the need to individualize care and develop primary care but offering change within existing parameters. Recently in Ireland, it has been indicated that discussion of, and planning for degree programmes for nurses is high on the agenda for the newly constituted Nursing Board (McNamara, 1987).

27. At the present time contradictions are apparent. For instance, health education and research are espoused as being important in nursing but are nurses really expected to be health educators or research minded? Is it expected, rewarded or inhibited in the clinical setting? I found no evidence of rewards but some of sanctions. These ambiguities must be resolved.

APPENDIX I

ADDITIONAL MATERIAL RELATING TO RECRUITMENT TO GENERAL NURSE TRAINING IN THE REPUBLIC OF IRELAND

The only figures available on applications for nurse training on a national basis are for 1977 to 1978 - they are as follows: for 1,134 training places, hospitals received 32,407 applications (1), although the actual number of individual applicants responsible for this number of questionnaires was 11,943. The overall multiple application ratio was 2.71:1 (Working Party Report 1980, p. 141). Of the applicants, fourteen point five per cent were twenty years and over.

The following table gives numbers of applicants for training per 1,000 female population in the 17/18/19 age groups in each health board area.

Health Board Area	No. of applicants/1,000 female pop. in 17/18/19 age groups
Eastern	60.99
Southern	197.50
Western	194.86
Mid-Western	198.07
North-Eastern	115.29
South-Eastern	162.92
North-Western	126.86
Midland	158.27

Ninety nine point seven nine per cent (99.79%) of all applications were from Irish Nationals. Ninety eight point eight three per cent (98.83%) of all applicants were female and single.

It was also indicated that forty nine point two four of applicants had

reached Intermediate or Group Certificate stage at the date of application but it should be borne in mind that eighteen point nine nine per cent of individual applicants were sixteen years or under and possibly not yet completed full-time education. The number of applicants with no educational qualifications was insignificant. More recent figures indicate sixty four per cent of all those on the student index for general nurse training had obtained at least two grade Cs in higher level papers in the Leaving Certificate Examinations (An Bord Altranais Report for 1984 and 1985, p.29).

Registration Examinations analysis for April/May 1986 were as follows:

General	No. taking examination	% passed	% failed
Part 1	521	92.5	7.5
Finals	654	95	5

(An Bord Altranais, 1986B)

(1) A total of 54,176 questionnaires were distributed and 32,407 (60%) returned. Also during the study period not all training hospitals advertised for applications for nurse training.

APPENDIX 11

Figure 1

APPROACHES TO THE STUDY OF NURSE SOCIALIZATION

STUDY	AIMS	METHOD	PERSPECTIVE
Olesen and Whittaker (1968)	To report on the students own views of becoming	Intensity, not extensiveness. Participant observation (of one class over three years) plus questionnaires semi-annual interviews, psychological measures, school documents.	Acculturation perspective - socialization is multi-dimensional - many sources of information exist for students.
Dingwall (1974A)	To understand how competent membership is arrived at for student health visitors.	Ethnographic observation of details of everyday life in health visitor school and other relevant organizations.	Acculturation perspective - suggesting an uncertain process and students' role in constructing the prevailing social order. Social organization of health visitor training should be focus not socialization. Socialization is multi-dimensional.
Davis (1975)	Identification of process by which students pass from 'lay to professional'.	Longitudinal observations, questionnaire study. Panel depth interviews.	Acculturation perspective-sees doctrinal conversion as the most crucial and problematic dimension of becoming professional.

Figure 1 continued

Simpson (1975)	*Learning of the nursing sub-culture and persistence of changes as students move through the programme.*	*Longitudinal questionnaire study designed around status transition, and diaries from panel classes. Interviews with students. Also questionnaire to faculty staff and to parents.*	*Combination of enculturation and acculturation perspective. But she considers that the persistence of change is the important factor. Three aspects of socialization are suggested:* *(1) Social Psycholigical* *(2) Temporal* *(3) Multi-dimensional*
Treacy (1979)	*Exploration of the sexual division of labour that exists in hospital and the relationship that exists between the male dominated medical profession and female dominated nursing.*	*Documentary sources plus the author's own experience of being a nurse.*	*Newby's (1975) deferential dialectic was used to analyse doctor-nurse interaction. This theory combines a structural and interactional framework of analysis.*
Melia (1981)	*Explores the student view of nursing through the analysis of students' accounts of their experiences.*	*Ethnography - in depth interview with 40 students.*	*Acculturation tradition. Grounded theory - data driven ethnographic account.*
Treacy (1987)	*To understand training from the students' point of view.*	*Qualitative - participant observation. Interviews with students and significant others.*	*Acculturation perspective. Subjective and objective reality are important - it continues Dingwall's approach but at a more structutral level of integrating/examining process and structure.*

APPENDIX III

A: DESCRIPTION OF STUDY HOSPITALS

All three hospitals included in the study are general hospitals. One of the hospitals occupies new premises, purpose built in the 1960s. Bed capacity is as follows:

St. Paul's	281
St. George's	500
St. Robert's	268

Unlike St. Paul's and St. Robert's, St. George's is run by a religious order. All three hospitals have recognised training schools for the general register. At the time of the study the following numbers of students were in training:

St. Paul's	245
St. George's	325
St. Robert's	157

The size of group intakes and blocks to the school varied between schools ranging from twenty five in St. Robert's to forty in St. Paul's. In each case, separate accommodation for the school of nursing existed; in two hospitals, this accommodation was purpose built, in all cases the accommodation was in a building separate from the main hospital. However, accommodation could be shared e.g. in St. Robert's to get to the nurses' home it is necessary to pass through the school of nursing.

Schools of Nursing

Within schools, accommodation varied - all three schools had libraries (with limited resources), and practical rooms. None had designated discussion areas/rooms and classrooms were set out formally with a dias for teachers and tables and chairs set out in rows for students. In one

school, the library was looked after by a volunteer helper, no school had a librarian and in general, books and journals were in limited supply.

Nurses' Homes

All three hospitals had nurses' homes. Two were modern buildings but one was older with more limited facilities. The nurses' homes were situated within the hospital complex and accommodation was shared e.g. in St. Paul's by assistant matrons and clinical teachers who had offices in the same building. In two of the hospitals staff lockers and changing rooms were also located in the nurses' home. In both St. Robert's and St. Paul's, residence in the nurses' home was compulsory for the first six months of training, while in St. George's students could be expected to live in for up to twenty-four months.

APPENDIX 111

B: OBSERVATION WARDS

Hospital	Ward	Spec.	Bed No.	Layout	Location of Nurses' Station
St. Paul's	Lister	Neuorsurgical and General Surgery	20	Open Nightingale type ward. Two side wards each with three beds.	Separate room, immediately outside the ward but separated from the ward by a wall.
St. Robert's	Simpson	General Surgery	17	Open Nightingale type ward.	'Glassed-in' area at top of ward.
St. George's	Pasteur	Medical	41	Both Pasteur and Hunter have three and eight bedded bays separated by a wall so each constitutes a separate entity. These mini wards are located off a long corridor and it is not possible to see from one to the other or move from one to the other without moving into the corridor.	Occupies a central position on a long corridor of 'mini-wards'. It constitutes a separate entity from the 'wards', as a solid wall cuts it off from 'wards'.
St. George's	Hunter	General Surgical	35		

APPENDIX 111

C: WEEKDAY STAFFING OF OBSERVATION WARDS

Hospital & Ward	Morning		Evening (after 4.30 p.m.)	
St. George's : Pasteur Ward	Ward Sister	1	Ward Sister	1
	Staff Nurses	2	Staff Nurses	1
	Third Years	2	Third Years	2
	Second Years	1	P.T.S. students	3
	P.T.S. students	2		
Trained to untrained ratios		3:5		2:5
St. George's: Hunter Ward	Ward Sister	1	Staff Nurses	3
	Staff Nurses	3	Third Years	2
	Third Years	2	Second Years	1
	Second Years	1		
	P.T.S. students	2		
	+ male orderly			
Trained to untrained ratios		4:5		3:3
St. Robert's: Simpson Ward	Ward Sister	1	Staff Nurse	1
	Staff Nurse	1	Third Years	1
	Second Years	1	First Years	4
	First Years	3		
Trained to untrained ratios		4:2		1:5

Hospital and Ward	Morning		Evening (after 4.30 p.m.)	
St. Paul's: Lister Ward	Staff Nurses	2	Staff Nurses	1
	Third Years	2	Third Years	2
	P.T.S. students	2	P.T.S. students	2
Trained to untrained ratios		4:2		4:1

APPENDIX III

D: ACCOUNT OF INTERVIEWS

Stage 1:

Subjects were given as much information as possible at the commencement of interviews. Each interview was started by explaining: "I am a nurse and I am doing a study of nurse training". At this stage, respondents were given an opportunity to ask questions. I emphasised (because it seemed clear that I needed to) that there were no right or wrong answers. I proceeded saying:

> "I'm interested in how you feel about nursing, about your experiences as student nurse/staff nurse/ward sister/tutor. What it means to you to be a student nurse/or etc. and how you feel about that..."

The interview then continued in an informal conversational style. Usually stage one was sufficient to generate an exchange. If this did not generate information or resulted in monosyllabic replies I would follow up with stage two saying:

Stage 2:

(For Students) "Tell me what stage of training you're at and how you felt about nursing when you first started?"

(For Trained Staff) "How long are you qualified and have you worked here since training

Purposely asking two questions together to get some kind of flow going! If the above failed to generate information I proceeded to ask respondents (trained and untrained alike):

Stage 3: "Could you compare how you felt when you first started nursing with how you fell about training now?"

and if this failed the following was used to generate information about nursing work:

Stage 4: "What makes good/bad days in nursing for you?"

Leads from respondents were followed up by saying:

"For example?"

"How?"

"Why?"

In addition the following questions were all used to trigger conversation/information when long pauses occurred. I did not often allow long pauses because they appeared to create anxiety for respondents:

"What did your family feel about nursing as a career?"

"What careers other than nursing had you considered?"

"Do/did you like living in the nurses' home?"

"Have you any favourite wards?"

"How does staff nurses' work differ from that of student nurses?"

Background information was obtained from all student nurses on:

Age
Stage of Training
Family background

APPENDIX 1V

A: PROFILES OF STUDENT NURSES INTERVIEWED: PILOT STUDY (1)

Name	Age last birthday	General Education (2)	Father's Occupation	Hospital	Stage of Training
Anne Marie Browne	19	Honours Leaving Certificate	Building Contractor	St. Paul's	Second Year
Karen Byrne	22	Honours Leaving Certificate	Estate Agent	St. Paul's	Third Year
Angela O'Connor	21	Pass Leaving Certificate	Builder	St. Paul's	Third Year
Mary Connolly	17	Honours Leaving Certificate	Farmer	St. Paul's	First Year
Avril Coogan	19	Honours Leaving Certificate	Company Director	St. Paul's	First Year
Helen Cox	21	Honours Leaving Certificate	Company Director - deceased	St. Paul's	Third Year
Anne Leahy	21	Pass Leaving Certificate	Medical Practitioner	St. Paul's	Third Year
Ailish Power	19	Honours Leaving Certificate	Headmaster - Vocational School	St. Paul's	Second Year

APPENDIX 1V

A: PROFILES OF STUDENT NURSES INTERVIEWED - MAIN STUDY

Name	Age last birthday	General Education	Father's Occupation	Hospital	Stage of Training
Rosemary Armstrong	20	Honours Leaving Certificate	Medical Practitioner	St. George's	Second Year
Joan Burke	19	Honours Leaving Certificate	Manager, Drapery Store	St. Robert's	Beginning Second Year
Rita Cooney	18	Honours Leaving Certificate (Six months of a Social Science Degree completed)	Managing Director, Brewery	St. George's	P.T.S.
Rachel Corrigan	20	Pass Leaving Certificate	Manager	St. George's	Second Year
Maire Cummins	24	Honours Leaving Certificate	Cash & Carry Manager	St. Robert's	Second Year (Paediatrics trained post-registration)
Mary Charlton	20	Honours Leaving Certificate	Farm Machine Labourer	St. Robert's	Third Year
Fiona D'Arcy	22	Honours Leaving Certificate	Insurance	St. Robert's	Third Year
Ruth Doyle	19	Honours Leaving Certificate	Deceased	St. Robert's	First Year
Ursula Dwyer	20	Pass Leaving Certificate	Medical Practitioner	St. George's	Third Year

Name	Age last birthday	General Education	Father's Occupation	Hospital	Stage of Training
Annette Elliott	20	Honours Leaving Certificate (First year of Arts Degree completed)	Pharmacist	St. George's	Second Year
Sarah Evans	19	Honours Leaving Certificate	Farmer	St. George's	Second Year
Kay Feary	18	Honours Leaving Certificate	Farmer	St. George's	Second Year
Peter Finnegan	23	Honours Leaving Certificate	Deceased		Second Year
Maria Fox	21	Honours Leaving Certificate (First year of Degree programme completed)	Medical Practitoner	St. George's	Third Year
Paula Jennings	19	Honours Leaving Certificate	Police Force Inspector	St. Robert's	First Year
Deirdre Kane	21	Honours Leaving Certificate	Medical Practitioner	St. George's	Third Year
Eva Lane	18	Honours Leaving Certificate (Six months of a Commerce Degree completed)	Company Director	St. George's	P.T.S.
Mary Kelly	18	Honours Leaving Certificate	Farmer	St. George's	P.T.S.

Name	Age last birthday	General Education	Father's Occupation	Hospital	Stage of Training
Eimear Long	21	Honours Leaving Certificate	Electrical Contractor	St. George's	Third Year
Sheila McCann	19	Honours Leaving Certificate	Purchasing Officer	St. Robert's	First Year
Carmel Macken	22	Pass Leaving Certificate	Farmer	St. George's	Second Year
Margaret Nally	21	Pass Leaving Certificate	Travel Agent	St. George's	Third Year
Patricia O'Brien	18	Honours Leaving Certificate	Farmer	St. Robert's	First Year
Angela O'Neill	21	Honours Leaving Certificate	Bank Official	St. George's	Third Year
Susan Reid	19	Honours Leaving Certificate	Farmer	St. George's	Second Year

(1) These profiles are included to present something of the student nurse's social milieu; they are in no way fictituous but it would be wrong to assume that an individual's profile could be constructed to be recognisable as a real person. While all data can be authenticated, it is not to be assumed that it is possible to reconstruct profiles to represent the individuals concerned.

(2) A Honours Leaving Certificate indicates that the student has obtained at least two Cs on higher papers and four Ds on ordinary papers in the Leaving Certificate Examination (see footnote 8, p. 121).

APPENDIX 1V

B: DETAILS OF TRAINED STAFF INTERVIEWED

Name	Role	Ward/Hospital
Sister Bush	Ward Sister	Hunter - St. George's
Sister Black	Deputy Ward Sister	Simpson - St. Robert's
Maria Carey	Staff Nurse	Pasteur - St. George's
Rita Fitzgerald	Tutor	St. George's
Ruth Kearns	Staff Nurse	Lister - St. Paul's
Anne Kennedy	Tutor	St. Paul's
Sarah Kenny	Tutor	St. George's
Pamela McKeown	Tutor	St. George's
Anne O'Riordan	Tutor	St. Robert's
Sister Peters	Deputy Ward Sister	Hunter - St. George's
Nuala Ryan	Clinical Teacher	St. George's
Clare Smith	Staff Nurse	Hunter - St. George's
Bernadette Ward	Staff Nurse	Simpson - St. Robert's
Sister Whyte	Ward Sister	Pasteur - St. George's

The above listing indicates those with whom formal interviews took place. Information was collected from many others in the course of informal discussion and participant observation; where appropriate their role and hospital are included in the text.

APPENDIX V

B: A STUDENTS' 'RELEASE BINGE FANTASY'

Eimear Long explains how and why she started smoking at boarding school:

M.T. "Do you smoke?

E.L. Yes I do.

M.T. Would you have smoked when you started nursing?

E.L. Yes, I smoked when I started nursing.

M.T. How many did you smoke when you started, how many a day would you smoke?

E.L. I started on the back of the bus at school, I thought it was fabulous, it was the best thing I ever did in my life! I probably smoked about ten one after the other at that stage! Then I didn't smoke again until I got a pass that term. I just took a few, but then I went through a period when I thought smoking was absolutely disgusting!

M.T. This was before you started nursing?

E.L. This was say fifth year in school, that's when it was. And I had no time for smoking and no time for anyone who smoked. As far as I was concerned my previous smoking was just totally an experiment and I had forgotten about it and that was it! But then I was at home for my summer holidays and I was very bored, and I just started smoking out of sheer honest to God boredom, smoking out the window, it was something to do! I have been smoking ever since!

M.T. Have you increased your smoking habit since?

E.L. Oh yes, I have increased my smoking habit literally in the last two months, because I was on night duty for seven weeks and when you are on night duty you smoke an awful lot more. During the night, I don't eat much during the night so I tend to smoke instead. When I came off night duty then I had a week's holiday at home, and I was not doing very much during the day, so I was smoking. Then when I came back into block I just noticed that my intake of cigarettes had gone from say fifteen to twenty a day!

M.T. You haven't found yourself, smoking more when you are on a particularly difficult ward maybe or after a particularly heavy day, when a lot of things have been happening?

E.L. No, I don't think so, I think because I initially started smoking out of sheer boredom, and because I kept smoking I found that instead of being bored at six o'clock in the evening, when there is nothing good on telly, I could go up and smoke a

cigarette out my room window, and I found that every evening I was smoking a cigarette out my room window at six o'clock in the evening, because it cured that bit of boredom! It became a habit, then when I was at school, when I went back to school for my last year, it was just a habit! I can remember thinking...I can't wait for the weekend!...on a Saturday morning we were allowed down town, of course a good time to have a few cigarettes! So that became a habit, every Saturday morning I did it! Just after that then when I finished school, I found that I could smoke when I wanted, and instead of...because I could smoke when I wanted to, instead of just saying it's no fun anymore or whatever, I did smoke, and it's just a habit. I don't think I respond any differently under anxiety or stress.

M.T. But presumably since you have come into nursing you have been exposed to a fair bit of evidence of the dangers of smoking. I just wonder have you ever made the connection between your own smoking and that end product like, cancer of the lungs or coronary heart disease or whatever?

E.L. I can't understand it because I can't even understand it in myself, I know and I am very aware of the dangers to your health. I have seen so many patients with cancer of the lungs, I have seen so many patients choking and gasping, perhaps dying! I worked in a vascular ward and every single patient there had PVD and they were having legs amputated every day, and I always made a point of asking them if they smoked, and every one of them smoked! I remember saying to someone...'Gosh, what am I doing?'

M.T. Did your mother and father smoke?

E.L. No. My father did smoke, but he gave them up years ago, but I can't understand...I think it is because it is such a habit, and I can't honestly say that I really really want to give up cigarettes! I've never really tried to give them up. I tried once, but I really didn't put my heart into it!

M.T. When do you find you smoke, say an average shift on a ward, say a morning shift, when would you find yourself smoking? Would you have a cigarette say, when you get up first thing in the morning?

E.L. No, not first thing, I would have it I suppose relatively early, but not as soon as I hop out of bed. What I used to do when I was working morning shift, because I am not terribly long in the flat, I used to get up in the morning, have breakfast or whatever, get the bus in, change really quickly, be ready and I would usually have a few minutes to spare and then that was the time I would have a cigarette, just before I went on duty. Then I would have another cigarette at coffee break, and I would really look forward to my coffee break for that cigarette! One time I really enjoy my cigarette is when I come off duty, that was the ultimate! When I actually did try to give up cigarettes, I managed no problem to cut out the cigarette in the morning, and coffee break even after dinner, although that was a bit hard! But I couldn't I just couldn't give up my cigarette when I came off duty! I think it's purely habit, I honestly don't think it's a response to anxiety and stress!

M.T. No, but would you think it's a form of relaxation for you now?

E.L. Oh it is I suppose, but I think it's just this thing...I will be getting off duty, and I can have a cigarette, and my work is finished for the day, and I can relax for the rest of the day! So it is from that point of view relaxation.

M.T. Do you play any sports or anything?

E.L. No vigorously no! I am very lazy!

M.T. Did you play a lot of sports in school?

E.L. No, we always avoided them! It wasn't that I was hopeless at them, but I wasn't too bad when I played them. I enjoyed tennis, I enjoyed badminton. Badminton, tennis and table tennis, mostly racquet games, and squash, but I didn't have much time for badminton. Hockey was another game I enjoyed but I never played any of them competitively purely played them only when I felt like playing them, and that was it! Even now, I joined a squash club, and I didn't even get my money's worth out of the club. When I go home there is a Community Centre at home and it's only newly opened, I have a game everyday of squash. But at the moment I don't go home very often."

APPENDIX V1

A: COMPOSITION OF EXAMINATION PAPERS

Registration Part 1

The examination papers consist of the following:

Paper	Section	Numbers of questions given	Numbers of questions to be answered
1	Anatomy and Physiology	7	5
2	General principles of health and nursing First Aid and Emergency Bacteriology Virology Parasitology Hygiene Dietetics Basic Pharmacology	7	5

REGISTRATION EXAMINATION (Written)

This will be held twice yearly in the second week of May and November.
The examination papers consist of the following:

Paper	Section	Numbers of questions given	Numbers of questions to be answered
1	Medical Nursing (General and Specialist)	8	5
2	Surgical Nursing (General and Specialist)	8	5

(An Bord Altranais, 1986A)

APPENDIX VI

B: PROFICIENCY ASSESSMENT FORM

An Bord Altranais
NURSING BOARD

PROFICIENCY ASSESSMENT FORM

Surname.....

Forename.....

Date of entry to present training .....

Ward/Department.....

Speciality ..... Day/night duty

From ..... To .. ..

No. of weeks.....

Preliminary interview date .....

Signature .....
Ward Sister/Charge Nurse

Signature .....
Student Nurse

Intermediate interview date.....

Signature .....
Ward Sister/Charge Nurse

Signature .....
Student Nurse

Please rate section below by placing "X" in appropriate box:
1 = Very Good. 2 = Good. 3 = Fair. 4 = Unsatisfactory

APPLICATION TO NURSING CARE	1	2	3	4
1 U es a opportun t es to ncrea e x ow edge and sk s				
2 Has responsible a l ude lo a endan e punctua ty				
3 Works wel without und e superv s on hav ng regard to eve ol tra n g				
4 Shows dependab ty sell re an e and ini a ve				
GENERAL RAT NG - APP CAT ON TO NURSING CARE				

ATTITUDE TO PATIENTS	1	2	3	4
1 Demonstrates ab ty to assess meet and evaluate pat en s needs				
2 Develops good nurse/patient re ationsh ps				
3 Shows good understand ng ol patient as an nd vidua				
4 Ga ns cont dence and co-operation ol patient				
GENERA RAT NG - ATTITUDE TO PAT ENTS				

QUALITY OF STUDENT'S PERFORMANCE	1	2	3	4
s accurate in performing dut es				
2 Adapts well to changed conditions				
3 Learns new duties well without undue repeated instructions				
4 P ans work effectively				
5 Has abil ty lo cope with pressure				
6 Shows high degree ol observation and accurately reports all relevant information				
7 Maintains high standards when carrying out nursing procedures				
8 Applies theoretical knowledge to nursing practice				
GENERAL RATING - QUALITY OF STUDENT'S PERFORMANCE				

RELATIONSHIP WITH CO-WORKERS	1	2	3	4
1 Works w as a member of the team				
2 Has a pos tive attitude to direction and supervision				
3 Shows w ngness to guide junior co leagues				
4 Has abi ity to work with other disciplines				
5 Is tactfu in working re ationships				
GENERAL RAT NG RELAT ONSHIP WITH CO-WORKERS				

ATTITUDE TO RELATIVES AND VISITORS	1	2	3	4
1 Shows consideration tolerance and tact				
2 Is approachable				
GENERAL RAT NG - ATTITUDE TO RELATIVES AND V S TORS				

ABILITY TO COMMUNICATE IN WRITING	1	2	3	4
1 Has ability to def ne essentials on which to plan and report				
2 Demonstrates ab lity to present c ear and accurate reports				
3 Can always be relied upon to record c inica data accurate y and promptly				
GENERAL RAT NG - AB L TY TO COMMUN CATE N WR T NG				

PROFESSIONAL BEHAVIOUR	1	2	3	4
1 Upholds the generally accepted standards ol the nursing profession				
2 Has reponsible attitude to importance ol confiden ia ity				
GENERAL RAT NG PROFESS ONAL BEHAV OUR				

ABILITY TO COMMUNICATE VERBALLY	1	2	3	4
1 Has ability to communicate wel through verbal expression				
2 s clear accurate and pos tive when g ving verba reports				
GENERAL RATING - ABILITY TO COMMUNICATE VERBALLY				

OVERALL PERFORMANCE RATING

Indicate overall rating by signing appropriate line below. If it is the assessor's intention to sign line 3 or 4, please discuss with the Matron/Chief Nurs ng Officer and Principal Tutor/Tutor.

1. Very good (performs very well) 1 .....

2. Good (performs moderately well without serious short-comings). 2 .....

3. Fair (does not function adequate y without constant supervision) 3 .....

4. Unsatisfactory (does not function even with constant supervision) 4 .....

I have discussed this complted form with the student nurse.

Signature ....
Ward Sister/Charge Nurse

Date ....

I have read this form and understand the contents.

Signature .. ..
Student Nurse

Date .. . .

ACTION PLAN FORM

Action plan form must be completed by the matron/chief nursing officer and principal tutor/tutor for all student nurses who receive an overall number 3 or number 4 rating in a proficiency assessment form.

Student nurse's name. . .....

Commenced training.....

Overall performance rating given
on proficiency assessment form.....

Date..... ....

Ward/Department.....

ACTION PROPOSED.....

.. ..

....

Signature . .. .
Matron/Chief Nursing Officer

Date . .. .

Signature ....
Principal Tutor/Tutor

Date..... . ...

I have read this form and understand the contents.

Signature ....
Student Nurse

Date..... . .. .

APPENDIX VI

C: EXAMINATION SCHEDULES

No of Receipt

Examination No

An Bord Altranais

Examination Schedule
Registration (Part 1) Examination

This schedule completely filled up, and accompanied by the appropriate fee* must be received by The Chief Executive Officer of an Bord Altranais 11 Fitzwilliam Place, Dublin before the latest date fixed for the receipt of Examination Fees

LATE ENTRIES WILL NOT BE ACCEPTED

Cheques, Postal Orders and Money Orders should be made payable to An Bord Altranais, Dublin, and crossed "Ulster Bank Ltd."

Name in Full (BLOCK LETTERS) . . . .

Date of Birth . . .
(State Birth Certificate must be forwarded)

Single, Married or Widow

HOME ADDRESS

. . . . . .

Present address (to which correspondence regarding the examination will be forwarded)

. . . .

If you have previously entered for
Registration (Part 1 Examination
state date

Name of approved Hospital or
Institution where trained

Centre where Candidate desires to be examined

Signature

Date

*NOTE Candidate not attending for the Examination shall forfeit fee unless absence was due to illness her necessary cause and either a Medical certificate given by a Medical Officer or by notification indicating the cause of absence is given to the Chief Executive Officer by the Candidates Training Hospital

APPENDIX A

CERTIFICATE OF PROFICIENCY IN CLINICAL NURSING SKILLS
REGISTRATION (PART 1) EXAMINATION

SURNAME: (block capitals).....

FORENAMES: (block capitals).....

TRAINING HOSPITAL:.....

(a) We hereby certify that the above student is considered by us to be proficient in clinical nursing skills consistent with the requirements for the Registration (Part 1) Examination.

Signed: (Matron).....

(Principal Tutor).....

(b) We hereby certify that the above student is not considered by us proficient in clinical nursing skills consistent with the requirements for the Registration (Part 1) Examination.

Signed. (Matron) .....

(Principal Tutor).....

DATE

CERTIFICATE OF CHARACTER

I certify that I have known . ...

.. ..

personally from . .. . to . . ..

and that.. ... . is of good moral character

Signature.... .. . .

Address.... . ...

Profession or Appointment . .. .

Date .. . .

CERTIFICATE OF INSTRUCTION

THIS CERTIFICATE MUST BE SIGNED BY THE MATRON OF THE HOSPITAL OR INSTITUTION WHERE THE CANDIDATE HAS RECEIVED TRAINING

I certify that..... ....

has undergone a Course of not less than Twelve Months Training in the wards of

... . Hospital . . . . . .

from . .. . to .. . . and has received not less than 75% of the Lectures in each Subject in the Course of Lectures required by An Bord Altranais and has received the training specified by the Board

Signature . . Matron

Date . .

An Bórd Altranais

FINAL EXAMINATION SCHEDULE.

This schedule, accurately completed AND accompained by the appropriate fee and enclosures, must be received by the

CHIEF EXECUTIVE OFFICER
AN BORD ALTRANAIS
11 FITZWILLIAM PLACE
DUBLIN 2

before the final date fixed for receipt f examination s hedul-s and fee .

The following MUST be enclosed :

Photocopy of candidate's marriage certificate if appl able
Appropriate fee of £ (cheques, money orders and p st l orders should be made payable to An Bord Altranais and r ssed "Ulster Bank Limite l").

Candidates not attending for the examination shall forfeit their fee unless absence was due to illness or other necessary cause and either.

1. a medical certificate is sent by or on behalf of the candidate to the Chief Executive Officer, An Bord Altranais,

or

2. notification indicating the cause of absence is sent at the time of withdrawal to the Chief Executive Officer, An Bord Altranais by the Matron or Chief Nursing Officer of the candidate's School of Nursing.

LATE ENTRIES WILL NOT BE ACCEPTED.

IF ANY CHANGES AS CERTIFIED IN THIS FORM OCCUR PRIOR TO THE DATE OF EXAMINATION, THE CHIEF EXECUTIVE OFFICER OF AN BORD ALTRANAIS MUST BE NOTIFIED IN WRITING.

I have read and will comply with the examination schedule regulati - .

Candidate's Signature_____

Date_____

School of Nursing_____

Division of Register applied for_____

No. of Receipt
Examination No
Reg. Receipt No
Registration No
Date
File No
Index No ...

Surname _____

Forename(s) _____
(as per Birth Certificate)

Marital Status _____

Date of marriage (if applicable) _____

Maiden Name (if applicable) _____

Home Address (for registration purposes) _____

_____

Address for correspondence regarding this examination _____

_____

If you are registered with An Bord Altranais, please complete the following:

Division of the Register	Number	Date of Registration
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you applying for this examination as a post-basic student (Yes/No) _____

Is this your first attempt at this examination (Yes/No) _____ _____

If you are re-sitting this examination please complete the following:

Section s in which you were unsuccessful	Date
_____	_____
_____	_____
_____	_____

Present school of Nursing _____

_____

Date of passing Registration (Part I or Preliminary Examination

_____

CERTIFICATE OF CHARACTER

I certify that I have personally known the said candidate and will testify that to my knowledge this candidate is of good personal and professional character.

1. Signature _____

   Title _____

   Date _____

2. Signature _____

   Title _____

   Date _____

CERTIFICATE OF INSTRUCTION

I certify that the said candidate is at present a student nurse in

_____ Hospital and commenced training on

_____ and will complete training on

_____ in accordance with the syllabus for

_____ nursing and has attended the prescribed arount of lectures in all subjects as required by An Bord and has received the training specified by An Bord.

Signatures: 1. Matron _____

Date _____

2. Principal Tutor _____

Date _____

ABSENCE FROM TRAINING (excluding holidays)

Certified Sick Leave	_____ days
Uncertified Sick Leave	_____ days
Maternity Leave	_____ days
Other Leave (specify)	_____ days
Total	

CANDIDATE'S CERTIFICATION

I certify that I have received the theoretical instruction and clinical instruction in accordance with the syllabus and that I have attended the prescribed amount of lectures in each subject, received the training as specified by An Bord and am eligible to sit for this examination for the _____ Division of the Register and that all information on this form is valid and accurate

Candidate's Signature _____

Date _____

CERTIFICATE OF PROFICIENCY IN CLINICAL NURSING SKILLS

(Registration Examination Candidates only)

Surname (Block letters)_____

Forename s) (Block letters)_____

As per Birth Certificate)

Training Hospital _____

The Matron/Director of Nursing/Chief Nursing Officer and the Principal Tutor/ Tutor must sign either A or B

A We hereby certify that the above student is considered by us to be proficient in clinical nursing skills consistent with the requirements for the Registrati n Examination.

Signatures: _____

Matron/Director of Nursing/Chief Nursing Officer

_____

Principal Tutor/Tutor

Date: _____

OR

B We hereby certify that the above student is not considered by us to be proficient in clinical nursing skills consistent with the requirements for the Registration Examination.

Signatures: _____

Matron/Director of Nursing/Chief Nursing Officer

_____

Principal Tutor/Tutor

Date: _____

APPENDIX V1

D: Extracts from a School of Nursing's Checklist

P.T.S.:

SUBJECT	P.T.S.	1st YR. BLOCK

MICRO ETC.

Infection/Cross Infection
Spread of Infection
Effects of Infection
Sources of Infection
Prevention of Infection
Sterilization and Disinfection
Pests
External Parasites
Internal Parasites
Food Poisoning

FIRST AID

Principles
Action at an Emergency
Dressings and Bandages
Asphyxia and Emergency Resuscitation
Unconsciousness
Burns and Scalds
Poisoning

PRACTICAL

The Central Laundry
Warning Page
Ward Management
Hospital Economy
Hazards to patients
Bed-Making
Pressure Areas
Accessories
Admission, Discharge and Tran fer

BLOCK:

COLLAGEN DISEASES:

1. Systemic Lupus Erythematosis
2. Polyarteritis Nedosa
3. Dermatomyositis
4. Scleroderma
5. Rheumatoid Arthritis
6. Gout
7. The following procedures in detail:-
   - Interarticular Injections
   - Synovial Fluid Aspiration

** In relation to the above disorders the following detail has been included:-
- Definitions
- Causes
- Pathology
- Symptoms and Signs
- Investigations
- Management:-
  - (a) Nursing (i) Physical
    (ii) Psych. incl. Spiritual care
  - (b) Medical/Surgical
- Prognosis
- After Care and Follow Up

SIGNED: _____

MISCELLANEOUS:

1. General Pre and Post-Operative Care
2. Wound Infection incl. Tetanus and Gas Gangrene
3. Neoplasms - Classification, Causes and Theories of causes, Signs of Recognition, Investigations and General lines of treatment

** In relation to the above disorders the following detail has been included:-
- Definitions
- Causes
- Pathology
- Symptoms and Signs
- Investigations
- Management:-
  - (a) Nursing (i) Physical
    (ii) Psych./Spiritual
  - (b) Medical/Surgical
- Prognosis
- After Care and Follow Up

SIGNED: _____

APPENDIX V1 E: TIMETABLE (Last week of a three week revision block for Registration Part 1)

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
8.00 a.m.	Assemble	Study-Revision	Study-Revision	Study	Study
8.30 a.m.	Miss O'Riordan (T)	Miss O'Riordan (T)		Miss Keogh (T)	Miss O'Riordan (T)
9.40 a.m.	BREAK	BREAK	BREAK	BREAK	BREAK
10.00 a.m.	Study	Miss O'Neill (T)	Miss O'Riordan (T)	Miss O'Neill (T)	Mrs. O'Connor (T)
11.00 a.m.	Miss O'Neill (T)	Study	Miss O'Neill (T)	Study	Study
12.00 - 12.45 p.m.	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH
12.45 p.m.	Miss Keogh (T)	Miss O'Riordan (T)	Miss Keogh (T)	Paper 1	Paper 11
2.00 p.m.	Miss O'Neill (T)	Miss O'Neill (T)	Miss O'Riordan (T)		
3.00 - 3.15 p.m.	BREAK	BREAK	BREAK		
3.15 p.m.	Miss O'Riordan (T)	Miss Keogh (T)	Miss O'Neill (T)		

(T) indicates Tutor

E: TIMETABLE (Fourth Week of a second year six week block)

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
8.30 a.m. - 9.30 a.m.	Dr. Sweeney (D)	Dr. Sweeney (D)	Miss Fitzgerald (T)	Miss Wynn (T)	Miss Manning (T)
9.35 a.m. - 10.30 a.m.	Miss Wynn (T)	Dr. Faulkner (D)	Mr. Rooney (D)		Dr. Doyle (D)
10.30 a.m. - 10.40 a.m.	BREAK	BREAK	BREAK	BREAK	BREAK
10.40 a.m. - 11.40 a.m.	Miss Manning (T)	Miss Manning (T)	Fr. Walsh		Miss Fitzgerald (T)
11.45 a.m. - 12.40 p.m.	Mr. Walsh	Dr. Swann (D)	Dr. O'Neill (D)	Practical on wards	Miss Wynn (T)
12.45 p.m. - 1.30 p.m.	Miss Wynn (T)	Dr. O'Neill (D)	Miss McHale	Mr. Kelly (D)	Miss McHale
1.30 p.m. - 2.00 p.m.	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH
2.00 p.m. - 3.00 p.m.	Miss Fitzgerald (T)	Miss McHale	Miss Fitzgerald (T)	Miss Fitzgerald (T)	Miss Fitzgerald (T)
3.15 p.m. - 4.00 p.m.	Mr. Lang (-4.30)	Mr. Ryan	Miss Mooney	Miss Fitzgerlad (T)	
4.00 p.m. - 5.00 p.m.	Study	Mr. Callen (D)	Mr. Callen (D)	Mr. Callen (D)	Miss Wynn (T)

(T) indicates Tutor
(D) indicates Doctor

APPENDIX VII

ADDITIONAL MATERIAL RELATING TO CHAPTER 7

A: WORK ALLOCATION BOOK:

The following is an extract from a page of a work allocation book on a ward in St. George's.

Wednesday afternoon

Report:	Nurse Walshe (3rd Year)
Admissions/Discharges:	Nurse Rooney (3rd Year)
Urines/Occult Bloods/) Collections:)	Nurse Lynch (P.T.S.) Nurse Rice (3rd Year)
Blood Pressures and four hourly observations:	Nurse Clarke (P.T.S.)
Creams: Internal, Eye and Ear:	Nurse Kiely (2nd Year)
Mycostatin Moutwashes:	Nurse Kiely (2nd Year)
Mixtures; Injections; Pill list:	Nurse Lynch (P.T.S.)
Enemas; Suppositories, Preparation for Barium Enema and I.V.P.:	Nurse Clare (P.T.S.) and Nurse Rooney (3rd Year)
Check Oxygen/Suction:	Staff Nurse
Cardiac Board/Trolley:	Staff Nurse

B: WORK ALLOCATION 'LIST'

In St. Paul's, a work allocation 'list' (compliled from respondents accounts) would be as follows:

Staff nurse's work is mainly administrative and attending to doctors' rounds, dressings and medications, ordering and checking drugs, reports, telephone, appointments. A third year student's work includes observations, care of drips and drainage, fluid balance, charts, bedbaths, tidying, etc. A second year student's work depends on what grades are on duty, assisting with observations, getting patients up, making beds, also bedbaths, etc. A first year student's work includes: recording temperatures, pulses and respirations and on some wards also cleaning of sluice room, sorting of laundry, cleaning and checking shelves and trays, feeding patients, assisting patients to toilet, cleaning bathroom, bedpans, etc.

C: A STUDENT'S DIARY:

The following is an excerpt from a student's diary; she is in St. George's and four weeks out of P.T.S., it is illustrative of 'working alone'.

10.30 a.m.	"I have been working alone for the morning and I went for coffee break with a 2nd year. Our coffee break lasts ten minutes and we returned to the ward and continued with out duties...
11.00 a.m.	Gave an injection under supervision of a staff nurse as it was only my second time giving one...
1.00 p.m.	<after lunch> returned to ward...before the 2 o'clock observations and blood pressures. These had to be started early as they have to be reported to a staff nurse and also be reported to the 3rd year who is writing the report for the afternoon shift...Charted intakes of patients on fluids, balance charts...
2.15 p.m.	Gave a phosphate enema to two patients. Results had to be reported. It was my first time giving an enema and there was nobody watching to make sure I did it correctly but however, I managed fine, much to my relief!

D: WORKING ALONE:

The following from observational records indicates how students 'work alone'. Joan Devlin (a Third Year), explained to me that she was doing 'checks'. On the ward Staff Nurse Smart was doing a drug round alone. She was in the same side ward as Joan. In the course of doing 'checks' Joan stopped and said that she must get blood for a patient in this side ward. I went with her to the station where she picked up the patient's chart and a pint of blood. The blood had been left standing at room termperature. Joan asked Staff Nurse Fitzpatrick to check the blood and chart. This completed, Joan contined alone to the patient's bedside, and put up the bottle of blood after she had put a drop per minute notice on the bottle. She then continued working alone, doing four hourly checks and fluid balance chart totals. Her only communication with patients was in the course of her work i.e. "I just want to take your termperature" or "did you drink a cup of tea?". As I observed Joan's work she continued to go around the patients on 'her side', checking wounds i.e. feeling if suture lines are red or sore. We passed Sr. Bush on the way. She had taken over the drug round from Staff Nurse Smart and was continuing with the drug round alone. The new P.T.S. nurses, now ten days on the ward, moved about their work alone.

E: REPORT SESSIONS:

The following extract indicates constraints on questioning at report time. The report session described was being delivered to four student nurses, two of whom were just out of Preliminary Training School (one on her first day on the wards, the other on her second). Staff nurses initial response to questions or explanations were soon abandoned saying: "The girls will explain it to you" i.e. the senior students. At another report session when Karen Byrne, a student who had just commenced her third year of training asked a question about the result of an investigation and a particular patient's diagnosis this was rapidly terminated by Staff Nurse Reilly saying: "We must get on or we will never finish report and the girls will never get off". As indicated earlier (ch. 7), during report little instruction is given and only the occasional question is asked; students are reluctant to ask questions of staff nurses and also the messages implied in some of the above are that the report session is not a place to discuss details and perhaps that students do not really need to know these items. Teaching by question asking of students was even less likely to take place where students both wrote and delivered the report - in these cases work role was more taken for granted. Students appeared to receive only the information they needed to function as workers on the wards and little recognition is given to their student status at report sessions in terms of teaching or explanation.

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